MEDICARE SELECT AND MEDICARE MANAGED CARE ISSUES

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT

OF THE

COMMITTEE ON COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

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MEDICARE SELECT AND MEDICARE MANAGED CARE ISSUES

WEDNESDAY, FEBRUARY 15, 1995

HOUSE OF REPRESENTATIVES,
COMMITTEE ON COMMERCE,
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:02 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Hastert, Barton, Stearns, Klug, Greenwood, Burr, Bilbray, Whitfield, Ganske, Norwood, Coburn, Bliley (ex officio), Waxman, Brown, Lincoln, Deutsch, Stupak, Wyden, Studds, and Pallone.

Also present: Representative Klink.

Mr. BILIRAKIS. The subcommittee will come to order, please. Good morning. I am pleased to convene our hearing this morning. This is our first hearing in the new Congress and probably the first ever under Republican Majority.

I welcome all the new and returning members of the subcommittee. Even though not many of them are here as yet, but I do look forward to working with all of you and I hope that we will work together productively.

I am especially pleased to have Mr. Waxman as our ranking member. We have worked long and hard over the years, sometimes together and sometimes on opposing sides, however, we have always worked together fairly and with mutual respect. I trust that we will be able to continue our strong working relationship and I know that both of us will do everything possible to ensure that is the case.

Today's hearing focuses on the Medicare Select program. As you all know, authority for this demonstration program expires at the end of June and we need to consider what future action we need to take to extend and/or revise it. I am especially pleased that the original sponsor and author of the program Nancy Johnson is here to testify on her bill, along with her coauthor, Congressman Pomeroy.

Medicare Select appears to be a very popular program. In August 1994, consumer reports rated the top medigap insurers nationwide. Out of the top-rated, 15 medigap plans were Medicare Select. I might also note that it is a very popular program in my home State of Florida where some 50,000 Medicare beneficiaries are enrolled. In addition, we will hear from a number of thoughtful people on

the prospects for providing more managed-care options under the Medicare program.

As the chairman of this subcommittee, and a Representative from the State of Florida, I am deeply concerned about the future of the Medicare program. Spending has been out of control, as we all know, for years. Beneficiaries are frightened by their benefits being reduced and Medicare providers are wondering if they will be able to stay in business. My district has one of the highest percentage of older Americans in the country, and as you can imagine, when I go home on the weekends, everyone wants to talk to me about Medicare.

As the new subcommittee chairman, I intend to do everything in my power to protect the benefits Medicare beneficiaries receive. It is obvious, however, that the Medicare program is in need of repair. Both the Medicare and Medicaid programs have been growing by double digit figures each year. Our responsibility as Members of Congress, I think, is to find ways to address this issue and other matters concerning the Medicare program.

Medicare has been functioning as a social program of the 1960's. It needs to be updated and reformed. And that is what we are all about.

The Chair will now recognize other members for opening statements. According to the rules of the committee, the Chair will recognize the ranking member for 5 minutes for an opening statement. He is not here. I suppose when he does come in, I will give him the courtesy of stopping the proceedings and letting him give his opening statement at that point. But we will recognize all other members for 3 minutes.

The Chair will recognize in the order of seniority those members who were present when the hearing began. Other members will be recognized in the order of their appearance.

So the Chair, at this point in time, I see the chairman of the full committee, Mr. Bliley, has come in.

Tom, do you have an opening statement?

Mr. BLILEY. Yes, I do. Thank you very much.

Today, is our first health care hearing in the 104th Congress for the Subcommittee on Health and Environment of the Commerce Committee. During the 103d Congress, I had the privilege to serve as the ranking minority member of this subcommittee as we worked our way through over 20 hearings on the administration's health care reform legislation.

Under the leadership of Mr. Waxman, this subcommittee set the standard for in-depth hearings in which the pivotal issues of health care were debated. In the 103d Congress, the membership of this subcommittee was a veritable "Who's Who" of leading players in the debate.

The Rowland-Bilirakis bipartisan bill, the Sterns-Nichols bill and the Cooper-Grandy bill all originated from members of this committee. I am sure that under the chairmanship of my good friend Mike Bilirakis, we will again be on the forefront of the health care and entitlement debate.

In 1995, the Federal Government will pay approximately $266 billion for the health care entitlements, Medicare, and Medicaid. For the past 5 years, these programs have been growing annually

at three to four times the inflation rate. One of the major challenges we face this year is how to slow the growth rates in both these programs while maintaining high-quality health care for beneficiaries.

I believe that to bring these programs into the 1990's, we must look to the successes of the private sector in containing costs. This chart is based on a study conducted by Foster Higgins which was reported by The Washington Post yesterday.

It shows that the cost of employee health benefits actually declined by 1.1 percent last year. This is the first time that health benefit costs have actually declined. And this is a real decline in premium payments, not a CBO-type cut where we are merely cutting the rate of increase in a program. This survey points out that the rise of managed-care plans, particularly the plans with a point-of-service option, was one of the key factors of this decision. As the second graph shows, the percentage of insured employees enrolled in managed care increased to 63 percent in 1994 compared to 52 the previous year.

Clearly, managed care is one of the potential areas that we must look at in the coming year as we attempt to rethink the health entitlement programs, but it is not the only solution. We must also guard against potential problem areas in managed care.

We are all aware that beneficiaries, physicians, and hospitals can be exploited in certain managed care arrangements. We must always remember that there is a delicate balance between high-quality and cost-efficient medical care.

Let me say that I welcome our two distinguished colleagues who will testify today on their bill on Medicare Select. Medicare Select is one managed care initiative that gives seniors the option of saving money on medigap policies by joining it to a preferred provider network. It was designed to give the elderly an up-to-date choice of a PPO product.

For years, Mrs. Johnson has been one of the most knowledgeable and articulate voices on health care reform. And I might add many other things. Before entering Congress Mr. Pomeroy had a distinguished career as the Insurance Commissioner of North Dakota and Chairman of the National Association of Insurance Commissioners. I warmly welcome them both.

Thank you very much, Mr. Chairman.

Mr. BILIRAKIS. I thank the chairman.

And the Chair would now recognize the gentleman from Oregon, Mr. Wyden, for 3 minutes.

Mr. WYDEN. Thank you very much, Mr. Chairman.

We want to congratulate you, Mr. Chairman. We have worked together often in the past. We have got today two of our very best colleagues talking about Medicare Select, and we welcome them.

Mr. Chairman and colleagues, I think that Medicare Select is an interesting innovation. But certainly, there are some questions that we ought to be asking.

In particular, I am somewhat troubled by the pricing arrangement, what is known as "attained-age pricing" where the older the beneficiary gets, the higher the premiums are. I think this kind of pricing system can be confusing for some seniors. And I think we are going to want to ask some questions today about those issues.

But I think most important, our colleagues need to recognize that Medicare Select is not a solution to the crisis that Medicare faces in this Congress. Given the areas of the budget that the Republicans have, in effect, put off the table, such areas as social security, veterans and the like, there is going to be great pressure in this Congress to cut Medicare.

There is discussion of doing it through savings and managed care. We certainly want to look at that. I have got some very good managed-care programs for seniors in Oregon. But the question is how can this be done, keeping choice and quality and still making the Draconian cuts in Medicare that seem to be envisaged by this budget.

I yield back.

Mr. BILIRAKIS. I thank the gentleman.

The gentleman from Iowa, Mr. Ganske.

Mr. GANSKE. Thank you, Mr. Chairman.

And thanks to our guests, Mrs. Johnson and Mr. Pomeroy, who have worked long and hard on this issue. I know that members of this committee have put in a tremendous amount of hard work on this issue in the past and I hope to be able to add some perspective to the good work that has already been done.

Mr. Chairman, as we discuss health care in the coming year, I would like to explain where I stand on a couple of basic issues. I believe that Federal policy should be neutral about how consumers purchase their health insurance, either through traditional insurance, through managed-care options or through out-of-pocket purchases, either directly or out of tax-free savings accounts. Right now, Federal and State policy favors employer-based insurance. On the other hand, many Federal and State policymakers seem determined to force Americans into managed-care plans.

Rising costs are driving the proposals. The reasons for the rising costs are known to everyone sitting in this room. We have an aging population and increasing technology. But let's be honest, the question is not whether there are going to be restrictions of services. The real question as we grapple with this problem, is who is going to make those decisions? The government, a vertically integrated insurance hospital industry, or the patient?

I am not anti-HMO. My family's insurance is a Select type, similar to the type that we are discussing today. But I have concerns about extending Medicare Select at this time to all States for the following reasons: first, we have not yet completed the study of these pilot programs. Before authorizing the national extension, I would think this committee would want to get feedback directly from consumers who have been served in these plans.

In light of the fact that in Florida we currently have eight Medicaid HMO's undergoing scrutiny for allegations of people dying from the HMO's failure to diagnose, I believe we should be cautious in acting without HCFA's final report.

Second, I would suggest that this committee examine the financial analysis of cost savings. According to a 1993 GAO report, "although many employers believe that in principle managed-care plans save money, little empirical evidence exists on the cost savings of managed care."

Third, I think we need to look at gatekeeper plans, especially in dealing with the elderly. Indications for treatment of the young are clear-cut. Treatment of pneumonia in a child is routine, but treatment of pneumonia in an elderly patient with Alzheimer's is not. The fiduciary implications of treatment need to be ethical.

Fourth, I am afraid that extending this program to all States will send the message that managed care will be the predominant direction of this country. I know that Chairman Bliley, Mr. Bilirakis and Mr. Thomas on Ways and Means, are interested in exploring medical savings account plans. I fear nationalizing this plan would give HMO's a significant head start. I believe that the consumer should ultimately end up with choices for their type of medical care and the elderly should have the same choices. And I am sure that our panelists feel the same way, and I look forward to their testimony.

Mr. BILIRAKIS. I thank the gentleman.

The gentleman from Massachusetts Mr. Studds?

Thank you.

The gentleman from Oklahoma, Mr. Coburn.

Mr. COBURN. Thank you, Mr. Chairman.

I think it is important this is the first real hearing to start discussing health care in this country. And I think it is instructive for us to look at how we got where we are. And I would propose to you that the results of our problems with Medicare and funding and financing it are a result of a political decision and the politicization of medicine.

We have developed a system where career politicians have promised something they can't deliver. And now that we are bringing about the reconciliation of a promise without the money there to supply it, we have come to a focal point in how to deal with that and how to become honest with the American public.

I think everybody would agree with the percentage of the Gross Domestic Product that is consumed in the health care field in this country today is excessive. I think that very few would agree with me that Medicare and the expenditures for it in terms of what the Medicare patient is getting today is excessive.

There is tremendous fraud, there is tremendous abuse and there is tremendous waste in the Medicare system today by all health care professionals. And it is that point at which we should be focusing.

I think one of the other things that we need to look at is that if we are going to design programs to help us out of this political as well as health care problem, that we have to design programs that are based on taking advantage of human strengths, rather than taking advantage of human weaknesses like many of the programs in the past have.

And so, Mr. Chairman, I look forward as we hear from our distinguished colleagues and these others that come to testify today so that we might start down—towards the goal of making sure every senior citizen in this country has quality health care that we as a country and they as an individual can afford.

Thank you very much.

Mr. BILIRAKIS. I thank the gentleman.

The gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman. I don't have an opening statement. I spent 2 years across the hall from Mr. Pomeroy so I will refrain from an opening statement, but I look forward to working with you in the next 2 years on this committee.

Thank you.

Mr. BILIRAKIS. I thank the gentleman.

I will at this point recognize my ranking member, Mr. Waxman, for as much time as he chooses to use.

Mr. WAXMAN. Thank you very much, Mr. Chairman.

Today, we are examining issues related to Medicare managed-care programs in general, and the Medicare Select program in particular. This is an important hearing and one that I hope will assist members in making informed judgments as we move ahead to consider legislation relating to changes in the Medicare program.

I think it is no secret that this hearing will be followed shortly with a markup of legislation to provide permanent status to the Medicare Select option for Medicare beneficiaries. Medicare Select has been in experimental status since 1992. It is a program that has had relatively broad participation in some States, like my own State of California, and very limited appeal both to insurers and beneficiaries in others.

I am not sure we have enough information available to us at this point to know what accounts for that difference. Medicare Select in its early experience has had some initial success in meeting the goal of providing a less expensive medigap product with apparently a reasonably high degree of consumer satisfaction with the provider choices offered. Yet again we do not have a very lengthy experience with the product. We do not know if the product was offered more widely by a larger variety of insurers whether the adequacy of the preferred-provider networks would be as satisfactory to the consumers.

We do not know if the premium will be reasonable in relationship to the benefits offered as beneficiaries age and their premiums rise. We do not know if the product will be effectively marketed to older and sicker people. We do not know if providers will be as anxious to discount rates to Medicare Select plans if a number of such plans are in competition in the same area.

What we do know is that the product has some promise and there are compelling arguments for keeping the existing products on the market. And we know that as with all significant changes in the Medicare program, we should move forward with caution and care that we maintain sensible protections for the Medicare beneficiary.

That caution should be paramount as we move to expand managed-care options in Medicare. We do not need additional scandals like the ones we had with Medicare HMO's in Florida in the 1980's. We do not want the kinds of problems we are currently seeing in Medicaid managed-care plans in Florida to be part of the Medicare program as well. I know every member here can agree on that.

Finally, I would note one more thing; Medicare Select may be a product that has some consumer acceptance, it may save beneficiaries money, but it is not a big saver for the Medicare program. Whatever else it is, it is not a model for managed-care entities that can be expected to save billions of Medicare program dollars.

There may be models that will save lots of Federal dollars, but the likelihood that that can happen without greatly restricting beneficiary choice, putting that beneficiary at much more severe financial risk or cutting benefits is doubtful.

I look forward to our hearing today and to the help our witnesses can give us to make sure the actions we take will benefit and protect Medicare beneficiaries in every State in this Nation.

I yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman.

The Chair would recognize the gentleman from Georgia, Mr. Norwood, for 3 minutes.

Mr. NORWOOD. Thank you, Mr. Chairman, and thank you very much for holding these very important hearings.

I look forward today to hearing from our witnesses. I especially want to hear the views of our colleagues, the gentlelady from Connecticut and the gentleman from North Dakota, and hearing about their bill regarding the expansion of the Medicare Select program. As a health care provider for over 25 years, I have a singular interest in making sure that health care quality is not compromised.

I can understand the growth of managed care, and perhaps it is the best solution to holding down the cost while at the same time covering more people. Maybe it is the correct way to go in Medicaid and maybe it is a viable option in Medicare. However, we need to make sure that we do not compromise the greatest health care system in the world.

For the sake of time, Mr. Chairman, I will yield back the balance of my time and hope that this committee will proceed in the spirit of brevity while at the same time covering today's subject very completely.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

In the interest of brevity and would recognize the gentleman from Ohio, Mr. Brown.

Mr. BROWN. No opening statement. Thank you.

Mr. BILIRAKIS. I particularly thank the gentleman from Ohio for that.

The gentleman, Mr. Burr.

Mr. BURR. Mr. Chairman, I would only welcome our panels today and ask for unanimous consent for my opening remarks to be included in the official record.

Mr. BILIRAKIS. I thank the gentleman.

[The prepared statement and additional questions of Mr. Burr follow:]

PREPARED STATEMENT OF HON. RICHARD BURR

Thank you, Mr. Chairman. I appreciate the opportunity to participate in this hearing today.

I come to the table with a unique perspective. Mr. Chairman, my district encompasses parts of both rural and urban areas in North Carolina. Looking at an area as small as my district, it is clear that a "one-size-fits-all" approach to Medicare will not appropriately cover the needs of all senior citizens. When placed on a state or national scale, it becomes obvious that a number of plan options are necessary to best meet the needs of seniors, doctors, and insurance providers.

Medicare Select has bridged the gap between the traditional fee-for-service and the managed care HMO plans by allowing patients a preferred provider network with a fee-for-service option. By increasing the menu of choices, Congress has an

opportunity to better meet the broad needs of seniors by offering versatility to the States while cutting Medicare costs.

Beyond the logistics of administering Medicare, lies the real question of the day—can we offer these options while maintaining a high level of quality in patient care. By implementing safeguards that require that networks offer access, provide a good understanding of network requirements, and ensure that networks maintain a high level of quality, patients should be adequately protected. In addition, the backup mechanism that allows patients to opt-out to traditional fee-for-service plans at any time should ease the minds of those seniors who need the added cost benefits of managed care but are understandably fearful of medical bureaucracy.

I believe that Medicare Select is a strong compromise between traditional programs and standard HMO alternatives that our seniors will be pleased to accept. Medicare Select is a move in the right direction as we face imminent changes in the public healthcare system. I hope that, by making it a permanent option, we can increase the number of participating Select providers to offer more variety in high quality healthcare while maintaining the peace of mind associated with personal choice. This is in the best interest of business, and more importantly, in the best interest of our growing population of senior citizens.

ADDITIONAL STATEMENT OF HON. RICHARD BURR

Mr. Chairman, because the vote preempted my questions to Dr. Vladeck in the second panel, I wish to submit the following statement into the record.

In light of the GAO report that Dr. Coburn brought to our attention, the rampant fraud and abuse of the current Medicare system, and the apparent inability or unwillingness of the Health Care Finance Agency to address these problems, I am hesitant to accept a report based on their findings as an accurate assessment of the Medicare Select system. As Congresswoman Johnson suggested in the first panel, the information that is available from a variety of credible sources might be a better avenue to pursue in evaluating the availability of adequate health for our seniors.

Furthermore, my concern about the adequacy of management within HCFA has heightened significantly as I have witnessed Dr. Vladeck's inability to address what should be among the most important questions before him today. If, in fact, fraud and abuse are costing the American taxpayers upward of $30 billion annually, and HCFA's response is as negligible as Dr. Vladeck's answers would indicate, the problems in our Nation's health care system are much deeper than I previously thought.

Mr. Chairman, the questions I intended to pose today queried the steps HCFA has taken to promote participation in Medicare Select programs. Congressman Pomeroy indicated that those steps were inadequate. His statement, in conjunction with information about the number of Medicare Select participants presented by Dr. Norwood, suggests that the pool for sampling success or failure is so small that a reliable conclusion could not be made from the data available to HCFA.

Rather than offering specific questions for the record, I would ask that Dr. Vladeck seek solutions to the substantial problems plaguing his agency, namely the fraud and abuse that are robbing the American Taxpayers blind.

Mr. BILIRAKIS. The gentleman from New Jersey, Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman.

I don't have a prepared statement, but I just wanted to point out that I do think this is a very important hearing. And the whole issue of Medicare Select and how it can be an example with regard to Medicare in general, I think is very important.

I would say, though, that we need to proceed with caution because I think most of the seniors that I talk to feel very strongly that any move to managed care has to be on a voluntary basis. And also they are very concerned about retaining—many people, that retaining their choice of physician and their fear of whether or not we may be getting into a situation where we ration care is legitimate. It very much depends, I think, on the State and locale as to whether managed-care systems work.

And that is why I think this should be primarily voluntarily. But I do think we need to look into this and spend some time in it, because the whole question of expanding managed care within the

Medicare system is a very important issue. So I am glad we are having the hearing.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman for his remarks, and certainly would agree with you this is a most important hearing and I am pleased to see the turnout here this morning.

The gentleman from Kentucky, Mr. Whitfield.

Mr. WHITFIELD. No statement, thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman from Pennsylvania, Mr. Klink.

Mr. KLINK. No statement, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Well——

Mr. STEARNS. Mr. Chairman?

Mr. BILIRAKIS. How could I miss the gentleman from Florida, Mr. Stearns.

Mr. STEARNS. Good morning. I ask unanimous consent to make my opening statement part of the record.

Mr. BILIRAKIS. Without objection, thank you.

[The prepared statement of Hon. Cliff Stearns follows:]

PREPARED STATEMENT OF HON. CLIFF STEARNS

Good morning. I am pleased to be here this morning. I would like to thank Chairman Bilirakis for holding this hearing today on the Medicare Select program. Like Chairman Bilirakis, I, too, look forward to working with the returning as well as the new members of the subcommittee.

While it would appear that this program seems to be very well received, the reason we are meeting today is to decide whether or not to make this program permanent and extend it to all 50 States.

As you know, the authority for this demonstration program will expire at the end of June 1995. I supported the 6-month extension to ensure continuation of this program past December 31, 1994.

The State of Florida is 1 of the 15 States participating in this pilot project with about 50,000 Floridians currently enrolled. I am pleased that both Congresswoman Nancy Johnson, who sponsored this program and Congressman Earl Pomeroy who co-authored it, are here to testify on the merits of the program.

Because our panel of experts have firsthand knowledge about the application of this Medi-Gap program, I look forward to hearing from them about the quality of service provided under this program as well as the savings realized.

In reviewing the statements of the various witnesses, I noted a general agreement about extending this program and making it permanent. The rationale for this expansion would be to avoid a series of extensions which would probably result in undermining the confidence of the beneficiaries.

Like Chairman Bilirakis, I have a large seniors population in my district and they depend on their Medicare benefits. Many seniors have expressed to me that they are scared about what the future holds for them. They wonder whether or not they will continue to receive health care through this program, or whether or not they will have to pay higher premiums for their benefits.

Not only are the beneficiaries concerned about the future of this program, but the providers such as physicians and hospitals worry about further reductions and the effect this would have on their ability to continue providing prescribed services.

The Medicare program will come under close Congressional scrutiny this year. I intend to do all that I can to protect the benefits Medicare beneficiaries receive mindful of the fact that both Medicare and Medicaid have had considerable cost overruns and both programs are in desperate need of an overhaul.

Last year I sponsored health care reform legislation that promoted choice for the consumer. I believe Medicare-Select provides our seniors with another option, thereby, allowing them a wider range of benefits from which to choose.

I would like to thank our panel of experts for being here this morning and look forward to hearing their insightful testimony.

Mr. BILIRAKIS. Well, thanks to the brevity of our members up here, we now can go into the testimony.

The first panel is already in place. It consists, of course, of Congresswoman Nancy Johnson of Connecticut and Congressman Earl Pomeroy.

I certainly welcome both of you. Thank you for appearing before the committee this morning. Your witness statements will be made part of the record, but we will certainly recognize each you for a summary of your testimony, and we will proceed to ask questions.

I would appreciate it if you could limit your testimony to 5 minutes, but if you have to go over a little while, we will certainly go along with that.

Nancy.

STATEMENT OF HON. NANCY L. JOHNSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CONNECTICUT

Mrs. JOHNSON. Thank you, Mr. Chairman. And I thank the members of the committee for their interest in this program and their commitment to the kind of scrutiny that it deserves to serve seniors in America.

It is a pleasure to come before you today to ask your support of H.R. 483 to make permanent and national one of Medicare's small but valuable programs, Medicare Select. In addition, I would ask for your prompt consideration of this bill because it must get through both Houses by the end of April if we are to avoid notification of policyholders of the impending termination of the program and increase in policy premiums. I think we have a responsibility to do whatever we are going to do in a time frame that doesn't upset coverage commitments to seniors in America. There are, after all, 400,000 Americans who have chosen Medicare Select.

Mr. Chairman, despite the limitations imposed on this very modest effort to allow seniors to elect the benefits of managed health care, Select policies have served both beneficiaries and the government well. And I emphasize "elect." This is a totally voluntary program. Everyone in it has chosen to be in it. There is nothing in the bill that we are proposing that is in any way mandatory.

As you know, the Medicare Select program is currently a demonstration project in only 15 States. Under Medicare Select, beneficiaries have the option to purchase medigap supplemental policies that offer Medicare services through managed-care networks.

Again, this is a medigap product. This is not a Medicare substitute. It ends up offering Medicare services through a PPO product, but it is the only access seniors have to any PPO network at all.

Currently, Medicare is a fee-for-service system with an HMO capability that is available in some areas. This is the only way seniors have any access to the PPO option.

Our experience has shown that Medicare Select products charge premiums that are 10 to 37 percent lower than the fee-for-service medigap insurance products. This translates into as much as $25 per month or $300 per year.

To an individual on a fixed income, this is a significant tangible savings. Furthermore, these products offer more services than you can get under other products. And that is one of the big reasons that seniors choose them. They often offer some prescription drug

coverage, some annual physical examination coverage, and dental and vision. They are highly efficient.

The chairman noted the positive report on them in the Consumer Report rating of medigap policies. Research Triangle Institute did a study and they noted that there were no consumer complaints with regard to these reports. And the National Association of Governors and the State Legislatures and the insurance commissioners all are in support of this bill.

I would also note that in last year's legislation in Senator Mitchell's bill, and the mainstream coalition bill, and the chairman's bill, which he introduced with our former colleague Dr. Rowland, in the Michel bill, in all but one of the major health care proposals in the last session, permanent extension of Medicare Select and expansion to all 50 States was recommended.

What has constrained the growth of these programs, as Mr. Waxman, I believe questioned in his opening statement, has been two things: First of all, its growth depends on the health of the managed-care networks in that State, so it depends how many there are as to how many Medicare Select policies are likely to be offered.

And second, the 3-year limitation has been a barrier to the growth of this program because it costs the company a fair amount to get it up on the market and to actually market it and to do all of that for a product life that by that time is 2 years or 2½ years, and Congress might not extend it, is not something that a lot of companies are willing to do. So there have been barriers to its growth.

Last, let me just say that I have spoken with Mr. Vladeck about this, of the Health Care Financing Administration, a number of times, and I regret that he has not been specific about the changes that he would like to make in this program. I hope to learn his thoughts as to how to improve it.

But his own testimony before the Ways and Means subcommittee shows why this Congress, this session, should make this program permanent. Nearly 3 out of 4 Americans, 74 percent of Medicare beneficiaries have access to managed-care plans, but fewer than 1 out of 10, that is 9 percent, have enrolled in a managed-care option. We need to make managed care an option on an entirely voluntarily basis, far more available to seniors, so that they can elect it as a choice.

I will leave the rest of my statement aside, Mr. Chairman, and look forward to the committee's questions.

[The prepared statement of Nancy L. Johnson follows:]

PREPARED STATEMENT OF HON. NANCY L. JOHNSON

It is a pleasure to come before you today to testify in support of H.R. 483 to make permanent and national one of Medicare's small but valuable programs—Medicare SELECT. In addition, I would ask for your prompt consideration of this bill as action on it needs to be completed by both Houses by the end of April if we are to avoid the notification of policyholders of the impending termination of the program and possible increase in their policy premiums.

Mr. Chairman, despite the limitations imposed on this very modest effort to allow senior citizens to elect the benefits of managed health care, Select policies have served both beneficiaries and the government well.

As you are aware, the Medicare Select program is currently a demonstration project allowed in only 15 States. Under Medicare Select, beneficiaries have the op-

tion to purchase their Medigap (Medicare Supplemental) policies through managed care networks. The program has been highly successful, with recent data showing that Medicare beneficiaries who elect to purchase Medicare Select products pay premiums 10 to 37 percent lower than the traditional fee-for-service Medigap products. This translates into savings of as much as $25 per month and $300 per year. Obviously, for individuals on fixed incomes, this represents very real, tangible savings.

In addition, these Medicare Select products are proving to be highly efficient and desirable among Medicare beneficiaries. In fact, *Consumer Reports,* in its August 1994 issue, rated the top 15 Medigap policies and found that 8 of the top 15 products were Medicare Select products. Almost all of the major reform bills introduced in the last Congress included provisions that expand the Medicare Select program to all 50 States and make it a permanent program. Finally the Medicare Select program enjoys the broad support of seniors groups, consumer advocates and insurers, as well as the Nation's governors, state legislatures and insurance commissioners.

The Congress authorized Select to operate for only 3 years, and to be available in only 15 States. One of the reasons we need to make the program permanent is to encourage the participation of well-developed, well-reputed managed care programs. The 3-year limitation of the initial authorization discouraged third-party insurers to invest in developing a policy, bearing the initial costs of the approval process and marketing a product with a 2 to 2½ year life. Permanent authorization of this program will expand seniors' choices. If in addition we allow plans to reflect the savings in lower premiums as well as increased benefits, as is currently plans' only option, we will create a range of health coverage choices to serve the needs of Medicare participants. With such expanded opportunities should come a more aggressive education effort to assure seniors clear and dependable information about the plans before them.

The Congress and the Health Care Financing Administration have been aware of the need for us to address the Medicare Select program since our passage of the 6-month extension bill at the end of the last session. Since that time—4 months ago—I have had a number of conversations with Mr. Vladeck to discuss his agency's concerns with Select and to obtain his thoughts on improving this program. Though he has not been specific in recommending changes to current law, Mr. Vladeck's own testimony before the Ways and Means Health Subcommittee shows why this Congress, this session, must make permanent the Select option for Medicare beneficiaries. According to Mr. Vladeck, nearly three out of four—74 percent of Medicare beneficiaries have access to a managed care plan, but less than 1 out of 10—9 percent—have enrolled in a managed care option.

While Mr. Vladeck maintained that Medicare does not share in any savings with the Select program and that managed care currently costs the Medicare program, subsequent testimony to our subcommittee revealed that for each 10 percent increase in the Medicare risk population's share of the Medicare market, per capita expenses in the Medicare fee-for-services sector decline by 1.2 percent. This finding is based on more recent data than the data upon which HCFA based its conclusions. Other studies confirm that the spread of managed care has indirect benefits on Medicare.

In conclusion, let me remind you that Medicare select is the only access seniors have to PPO plans. Our Medicare risk contracts are entirely with HMO's. Offering seniors the opportunity to choose a PPO, and especially one governed by both Federal and state regulations, seems only fair and prudent in today's world.

I thank you for your consideration and would be happy to answer any questions.

Mr. BILIRAKIS. Thank you.

The Chair now recognizes the Honorable Earl Pomeroy.

STATEMENT OF HON. EARL POMEROY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. POMEROY. Thank you, Mr. Chairman.

It has been my pleasure to testify in this room on a number of occasions as a State insurance commissioner. I never imagined testifying as a member of this institution, particularly a minority member of this institution.

I want to start my statement by commending Nancy Johnson, because without her focused determination, we would not be here. The program would have expired last year. And as I will indicate, I think that would have been a terrible mistake. Her determination

got us this 6-month extension, but no program can prosper or treat its consumers fairly on a 6-month-to-6-month lease basis.

My interest in senior citizen insurance protection goes back a long time. Ten years ago, I was elected North Dakota's Insurance Commissioner, and during the time I served in that position, I focused on senior issues. I chaired the NAIC Task Force on long-term care, and I served as president of the association. I was Chair of the medigap group at the time we were charged by Congress through OBRA 1990 to develop standardized packages for the medigap insurance. And that same legislation brought in place the MedSelect program.

From the get-go, Medicare Select struck me as the smallest initiative imaginable; truly a baby step down the path of incremental health reform. It allows insurers to negotiate with hospitals to reduce the deductible charges and pass the savings on to the insured.

There is hope that if this occurred in the context of a managed-care network, Medicare would benefit from managed care savings that might be generated. Not surprisingly, our experience to date shows that most of these are in essentially PPO arrangements and the discount is passed on to the consumer, and that is about it, with little or no beneficial managed care occurring.

On the other hand, for a number of insurers, a provider network with a discount is offered to their managed-care network. In these instances, care is managed and savings has resulted, which enhance the premium discount enjoyed by the senior citizen insured and pass some savings along to Medicare.

Frankly, I thought at the time of Medicare Select's enactment, subjecting such a tiny program to such scrutiny was oversight overkill. I think the primary effect of this limited pilot project has been to deny the seniors in 35 States from enjoying the premium discounts those of us in the 15 States have been able to enjoy.

We have some initial results and the following conclusions are supported: Medicare has not quantified savings nor have they quantified additional costs from the programs. Insurers find this a useful policy feature to bring Medicare supplement policyholder to their network. Maybe I am missing something, but it seems that we ought to preserve a program that at its worst is a benign presence in the marketplace—along the lines of what Congressman Ganske said, offering choice.

When I was an insurance regulator, I figured the insurance consumers knew more about their unique circumstances than I did as a regulator, and offering them a choice was an important public policy objective. In North Dakota, the choice has been important: 10,000 policyholders enjoying a 17 percent premium discount.

To date, not a single complaint has been filed with the North Dakota Insurance Department, and I have tracked that very closely. Anyway, my brother is the present North Dakota Insurance Commissioner. The Department has gone to rack and ruin. Not a single Medicare Select complaint. The experience in each of 15 States shows that those who have Medicare Select like it. And concerns about the program tend to be theoretical or anecdotal.

I find the actual experience of those in the program to be most instructive in terms of whether this works or not, and I think that it works. Applying it to all 50 States will have several positive ef-

fects. The national trend towards managed care will make it increasingly likely that Medicare Select enrollees will benefit from lower premiums through established networks of providers, but, as always, at their choice.

As we take this step, it is appropriate to consider if we can enhance and improve this program. In order to provide greater savings to policyholders, discount on the part B premium should be perhaps permitted similar to the party discounts presently allowed. Adequacy of consumer protections should be evaluated provided that the protections urged for the Medicare Select program are similar to those urged for the rest of the market. This is primarily an indemnity product, and whatever changes in this program, should be appropriate for the underpinning of this product.

In conclusion, I would urge this committee not to let perfection be the enemy of the good. Could this product be better? Probably.

Could we deal with concerns about managed care beyond what is here? Probably.

But what we have is a program that works in a modest way for those who have it, and let's not let it lapse as we contemplate how we can fix the health insurance problems that we have as a country.

Thank you.

[The prepared statement of Hon. Earl Pomeroy follows:]

PREPARED STATEMENT OF HON. EARL POMEROY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NORTH DAKOTA

Mr. Chairman, I commend you for holding this hearing today to discuss the Medicare Select program. I appreciate this opportunity to testify in support of the program.

I have had a long interest in senior citizen insurance coverages dating back to my days in the North Dakota State Legislature in the early 1980's. Ten years ago, I became North Dakota's Insurance Commissioner and during the 8 years I served in that position, I worked aggressively in North Dakota and in the National Association of Insurance Commissioners (NAIC) to upgrade the health insurance marketplace for senior citizens.

Within the NAIC, I served at various times as chair of the Medicare Supplement Task Force, the long term care insurance task force, as well as President of the association. When OBRA 1990 created the standards for Medicare supplement coverage and the Medicare Select program, I chaired the task force that developed the model statutes and regulations implemented at the state level pursuant to the legislation. These model laws included designing the spectrum of standardized coverages presently allowed in the Medicare supplement market.

The Medicare Select initiative was from the get-go a modest little experiment—a baby step down the lane of incremental health reform.

Medicare Select allowed insurers to negotiate with hospitals for reduced part A deductible charges and pass the savings on to the insured. Medicare paid claims in an identical manner to other medigap policies but stood to benefit from utilization reduction.

Not surprisingly, the primary arrangement presently in place on Medicare Select plans is a restricted network of providers passing on the discount and providing little or no additional managed care to obtain additional savings.

On the other hand, for a number of insurers the provider networks where the discount is offered is the same network the have constructed to provide cost efficient managed care services to their insureds—major medical and Medicare Select alike. In these instances, even deeper premium discounts are made available to insureds because of managed care savings. Of course, Medicare and taxpayers also benefit because the insured has selected a more cost-efficient health care provider.

Frankly, I thought at the time of enactment that subjecting such a modest project to the status of a pilot experiment by allowing it in only 15 States and for a relatively short period of time was oversight overkill. In my opinion, the biggest consequence of these limitations has been to deprive seniors in 35 States from a

medigap insurance option which could have saved them some money while promoting managed care.

Anyway, now that we have the initial results, the following conclusions are supported:

—Not many consumers have it but those who do enjoy lower premiums and register high levels of satisfaction.

—Medicare has not quantified savings or costs from the program.

—Insurers—particularly those with established managed care networks—find Medicare Select a useful policy feature to bring to their managed care network.

Maybe I'm missing something, but it seems to me we ought to preserve a program that at its very worst has been a benign presence in the senior insurance marketplace.

When I was an insurance regulator, I figured the insurance consumers knew a lot about their unique circumstances and they wanted options available in the market to choose from. With Medicare Select there is no demonstration that seniors should be precluded by government from having the option of swing a little money by selecting a medigap policy that involves a restricted provider network and managed care.

In North Dakota's experience the Medicare Select program has more than 10,000 enrollees who pay premiums priced 17 percent below those insured in conventional medigap coverage. To date, the insurance department has not received a single complaint from a Medicare Select policy holder.

The experience to date in each of the 15 States tends to show that when it comes to Medicare Select, those who have it like it. Concerns about the program tend to be theoretical or anecdotal. I find the actual experience of those in the program to be more instructive about the merit of the Medicare Select program than those who purport to speak on their behalf.

In my opinion, applying Medicare Select to all 50 States and making it permanent will have several positive effects. The national trends toward managed care rather than traditional fee-for-service reimbursement make it increasingly likely Medicare Select enrollees will benefit from lower premiums and managed care provided through established networks of providers.

As we take this step, it is certainly appropriate to consider improvements to enhance the program.

In order to provide greater savings to policyholders, discounts on the part B deductible should be permitted similar to the part A deductible discount presently allowed.

The adequacy of consumer protections should be evaluated, provided that the extent of existing protections are found to be insufficient. In this regard, perhaps more should be done to ensure that every Medicare Select insured has an ongoing opportunity to change to conventional insurance on a one-time basis.

Additional protections should retain regulatory responsibility with state insurance regulators and be appropriate for the indemnity-based nature of the product.

Unfortunately, the 6-month extension allowed by the 103rd Congress is not sufficient to thoroughly consider design improvements without placing the existing programs at risk of having the program's authority expire. I hope this Congress will not let perfection be the enemy of the good. The consideration of refinements must not jeopardize the Medicare Select program or unnecessarily complicate things for those who have stepped forward to provide this coverage.

In summary, I believe the results of the Medicare Select program justify its extension and national expansion. Thank you for your consideration.

Mr. BILIRAKIS. I thank both of our witnesses.

The Chair would now recognize himself for 5 minutes and then continue on to the rest of the members.

I would ask both of you if you know what is the view of physicians with regard to Medicare Select? We haven't heard anything towards that end.

Mrs. JOHNSON. We will try to get you more precise information, but the view of physicians is probably going to vary according to their view of managed care in general. Some physicians have participated in HMO service organizations for many, many years, and they think it is wonderful. Many practicing physicians think HMO's are really terrible. The same variety of opinion exists in regard to managed-care plans.

I would say, representing a State where managed care developed rather late and has made enormous strides in the last few years, there are variations in managed-care plans and how they oversee utilization and things like that. What I see happening in the market is greater and greater choice being afforded to both physicians in terms of treatment options and to consumers in terms of physician choice. And that pleases me very much.

The market is responding to the concerns of both physicians and consumers that networks can be too constrictive at certain times and I am pleased to see that. But I think that any physician attitude is based on their concerns about what is happening in the market and is not Medicare Select-specific.

Mr. POMEROY. I concur.

Mr. BILIRAKIS. The administration's testimony notes two specific concerns with regard to the continuation and expansion of Medicare Select, and I would appreciate your comments on both of these. First, the administration is concerned that there are insufficient beneficiary protections because there is no specific requirement for a State to review actual operations to assure that access and quality are met once the plan has been approved.

And second—and Mr. Waxman alluded to this—the administration points out that it does not save the Federal Government any money, thus, asking the question, does it add efficiency to the Medicare program?

The bottom line is what is the need for it if there are not any savings and if there are not any specific requirements in terms of beneficiary protections?

Mr. Pomeroy?

Mr. POMEROY. Mr. Chairman, I will answer the second part of that question first. I believe there is potential for some very modest Medicare savings into the future as the Medicare Select product is increasingly made available through managed-care plans and networks.

On the other hand, what is the harm of allowing this feature in the marketplace if it is saving consumers medigap savings and they essentially are comfortable and like the coverage? That would be my opinion. Whether or not HCFA enjoys enormous savings or not is not the key to whether this program ought to be expanded and continued.

Second, there are a series of protections required for these coverages. In fact, I will just list some of them for you. The networks must offer sufficient access; networks must have ongoing quality assurance programs; the insurer must provide disclosure at the time of enrollment; and provision for out-of-area and emergency coverage must be made.

Now, in the event these would prove to be insufficient, we should strongly encourage State regulators to get on top of it. But I believe their testimony today will reveal that they have been focusing on this. I think that sometimes there is a tendency at the Federal level to try and imagine every conceivable problem that there could be and ask whether there is a law against it.

In point in fact, State regulators are hands-on and connected to the concerns of their consumers. Most would have 800 numbers coming into their office, relative to complaints, and be prepared to

quickly respond with such regulatory restrictions as are appropriate. It is my belief, certainly, when I was a member of the NAIC, relative to Medicare Select, I believe those protections were in place and I believe they continue to be in place.

Mrs. JOHNSON. I would just like to make very clear that medigap insurance policies all are regulated. They all are by Federal laws, governing waiting periods, preexisting condition exclusions, and premium refund provisions, and some have specific additional requirements that my colleague just pointed out, about the sufficiency of provider networks and quality assurance programs and informing consumers, and emergency services. Then the States go on and repeat a lot of those requirements and do oversee these things quite completely.

Before my subcommittee Josephine Musser of Wisconsin testified on behalf of the National Association of Insurance Commissioners, and if she is going to testify or someone from that organization is going to testify today, she gave very specific and detailed testimony about what is required and about their experience with consumer complaints, and it is very impressive with Medicare Select.

As to the money and cost savings, first of all, there is a lot of evidence that the people enjoy lower premiums and lower costs under these Medicare Select plans. And that matters. I mean, whether people are allowed to save money, that matters.

But there is also increasing evidence that the government benefits. There have been a number of studies done.

Are you going to have testimony from BlueCross/BlueShield of California?

Mr. BILIRAKIS. Yes.

Mrs. JOHNSON. They will share with you their data about how Medicare expenditures are lowered by the presence of managed care participation by seniors through Medicare Select and HMO risk contracts. I think over the course of the day, you will get a lot of evidence of particularly the indirect savings to Medicare. And if not, I would be happy to provide you with some of the studies that were discussed in front of my subcommittee.

Mr. BILIRAKIS. Thank you.

Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

I want to commend both of you for your leadership in this area.

As we look at Medicare Select, does your bill do anything to protect people from increased premiums as they get older and sicker? Is that something you think that we can deal with?

I know you are concerned about trying to have a law for every potential problem, but that is a likely problem for people when they do get older and sicker, if their premiums are going to be too high, they will not be able to afford it.

Do you have anything to deal with that? Any suggestions?

Mr. POMEROY. Congressman, when I was insurance commissioner, attained-age rating of medigap was never an issue that was brought up, which is surprising to me, in light of the time and focus I spent on medigap coverages; I think it was because the premiums were relatively inexpensive, in light of them covering only a small portion of the total exposure.

I think that there are several public policy considerations that weigh strongly against attained-age rating. I don't believe that as a person gets older and their financial circumstances become closer to being depleted, that they ought to be at the highest end of their premium. And in fact, in light of the relatively limited age group, 65 and over to start with, and then the limited risk of the product, which is what a medigap coverage would cover, there ought not be attained-age rating.

Now, I am not sure that this bill ought to be the place where this issue is addressed. I think that is a problem with all medigap coverages, to the extent that it is driving people out of coverage.

Mr. WAXMAN. The reason why it is a problem here is that in some places like in California, if you want to drop out of the Medicare Select, and you stay in the area, the insurance company will have to offer you one of their own products. But in other places, they may not have other products and then the question is what will they have available to them?

These are different issues, but they are not unrelated. I guess my point to you is I would like to work with you on those issues. I am concerned.

Mr. POMEROY. I would have hated to have this applied to Medicare Select policies and not the other policies, and Medicare Select policies be price disadvantaged relative to the others.

Mr. WAXMAN. I think that is a fair comment.

Mrs. JOHNSON. This is a problem in all medigap policies. Medicare Select is just one of the medigap policy alternatives. Medigap insurance covers all those costs that Medicare does not cover, so seniors have Medicare and then one buys medigap insurance to cover copayments and other things not covered. And there is a variety of medigap policies and we regulate them all. We tell them exactly how they have to market themselves and what their loss ratio should be, and so on, and so forth.

We do not address the issue of rating methods. And it is true that later on in the testimony you will see from the chart you will receive that some policies use attained-age rating, some use community rating, some use issue age and there is a variety of methods. This is not an issue that we could address in this little bill. It is an issue that you might want to address in larger medigap reform legislation.

Mr. WAXMAN. As people get older and get sicker and have a greater need for medical attention, they may not want to be in Medicare Select.

Mrs. JOHNSON. I meant to continue on what happens if you are in Medicare Select and you want to get out, exactly the same thing happens as if you were in any other medigap insurance policy. If you are in an insurance policy that you don't like and you want to change, you can drop it and choose another in the market.

Now, some in the market do not medically underwrite and some do. And you have to look at the market, see what your choices were, both in terms of eligibility and in terms of cost. But the market does provide quite a variety of options.

Your choices would be no different leaving Medicare Select than they would be leaving any other medigap policy. And I think that is the critical point here. There would be one difference. Since you

are in Medicare Select, you probably are in a managed-care network. And so then you would just go into the fee-for-service system for your Medicare benefits like any other Medicare recipient.

Mr. WAXMAN. Shouldn't we require a company that offers Medicare Select to also offer a basic medigap plan? And is that not a good protection for a person who might become dissatisfied with the provider network of a Medicare Select plan?

Mrs. JOHNSON. We do require that if an insurer offered both, you can automatically go into the other, but if you require a company to offer both, it may be that all they offer are PPO's. Maybe all the care they offer is within a network and they may not have the capability to offer an alternative.

Mr. POMEROY. I think that HMO's that do not have the other product availability could contract with another insurer for that coverage. It would be difficult from a pricing standpoint, but it could be done. And perhaps it ought to be done.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Ganske.

Mr. GANSKE. Mr. Pomeroy, the cost savings attributed to Medicare Select premiums may be more apparent than real. Insurance companies that write Medicare Select policies typically are able to avoid paying hospital deductibles because of their discounting arrangements that they have with hospitals.

Consumer's Union later today is going to argue that these costs are just shifted to other patients. Would you care to comment on that?

Mr. POMEROY. There are many insurance arrangements with medical providers that involve discounts and passing discounts on to policyholders in the form of reduced premiums.

See, I don't think we ought to break out senior citizens and treat them different than the rest of the population. Why should we allow that to take place for all the rest of the population, but we get to this senior block that we suddenly become paternal and say, well, we don't think that you ought to be able to enjoy premium savings from discounting arrangements like the rest of the market. I don't see the public policy rationale for that.

And to follow up on your words in the opening, which I thought was very interesting, one point that I strongly agreed with is the issue of choices. We ought to give our seniors choices like the rest of the market and that is why I think those choices ought to be made available.

Mr. GANSKE. Let me give both you and Mrs. Johnson an opportunity to put your best case forward for why we should not wait until we get the HCFA report. Later today, they are going to be before us, and so I get the opportunity to ask them why their report isn't more timely. But go ahead.

Mrs. JOHNSON. Let me just say that last year, I asked HCFA to accelerate their work on their report because the law was going to expire December 31st, and we needed to know and we needed to act and they agreed that they would. When we passed the extension, they knew what the deadlines were and when we needed the information.

The insurance commissioners who are going to testify before you have a lot of information about consumer satisfaction. The two

things that we need to look at that they haven't yet looked at, are consumer satisfaction and utilization review. Are they getting the services? Is the network adequate? Those are the two things that report is supposed to talk about.

You will find from the testimony that you are going to hear, that there is a lot of information about consumer satisfaction. And that States, in fact, are doing a lot to assure that information about consumer satisfaction is very public for every managed-care system. So that issue, I think, is being broadly addressed and very specifically addressed, in this instance.

In addition, in terms of utilization review, is the network adequate? I do not know of a single State that isn't serious about looking at that issue in regard to their own managed-care plans, because States require managed-care plans to provide adequate networks and they will not certify a managed-care plan that says you have access to a physician if you have to travel 50 miles to do it.

One of the issues that I have talked to regulators about a lot and managed-care providers a lot, is the issue of pharmacy access. And consumers want pharmacy access, not mail-order access. And the managed-care plans are responding to that. When you look at all the plans in place to see whether the network is adequate and whether the utilization review oversight is adequate and whether consumers are satisfied, they are multileveled, they are powerful, they are right out there. And I don't know why HCFA has not been able to develop this information.

But my understanding from other conversations with them off the record, rather than on the record, is that they basically would like to regulate the managed-care plans that offer Medicare Select in the way they regulate HMO's that offer HMO risk contracts. I don't think that is necessary.

These managed-care plans are serving lots of Americans, and one of the provisions in this bill is if you are 64 and participating in a managed-care plan that you like and that managed-care plan that you are on wants to offer a Medicare Select program, you could stay on that program. I can tell you there is a lot of information out there to address those very issues. That information should be heard.

Mr. BILIRAKIS. I would announce at this point, that certainly the Chair does not intend to preclude anyone from asking questions, but I understand that Mrs. Johnson has to leave at 11:15, and the HCFA Administrator will have to leave at noon, and he is the next panel, and so we should all take that into consideration.

Mr. Wyden.

Mr. WYDEN. Thank you, Mr. Chairman.

Mr. Pomeroy, I particularly appreciate your concern about attained-age pricing. I suspect, for example, one of the reasons there haven't been a lot of complaints yet about Medicare Select is that a lot of people haven't yet seen that ratcheting up in prices that will accompany attained-age pricing, and I think it is one of the reasons that I and others want to follow this a bit closer.

The question I have for you—and I appreciate that the chairman does want to move on—do we have any data on how many other medigap providers give up their part A deductibility? It looks to me like all of the savings essentially come because you have these

medigap providers giving up their part A deductibility. And I wonder if we have any data on how many other medigap providers give up that big source of money or is it just Medicare Select people who do.

Mr. POMEROY. It is my understanding that is permitted within the MedSelect arrangement, not permitted as a kickback, an impermissible kickback in a non-Medicare Select arrangement.

Mr. WYDEN. I have to say that it just seems to me that on its face, we are talking about a cost shift to non-Medicare Select patients and their insurers. I think that this is an interesting kind of a product, and frankly, I would go into any cause with a bias in favor of what Nancy Johnson and Earl Pomeroy are interested in, because of their commitment on these issues. But particularly at a time when Medicare is going to be faced with a cut, in my view, of upwards of $50 billion, this is troubling. I mean, Medicare is facing the most Draconian cuts certainly in my career in public service. I think we ought to recognize that this is not a silver bullet. And I am going to work closely with you particularly so that we can move forward by that April date.

Mrs. JOHNSON. The savings that are being passed on to seniors are only the very same savings that managed-care plans are passing on to nonseniors. It is identical. The deal they cut with the hospital for real world working people is the same deal from which seniors are benefitting.

And on this issue of cost, you really have to look at the fact that most of these plans also offer additional benefits. Some of them offer $500 of prescription drugs, plus a regular physical, plus some vision, plus some dental, plus copayment coverage, all for no additional premium. It varies from place to place. But you will hear that Wisconsin people get 20 to 30 percent lower premiums. I think you have to recognize that this is both additional services and utilization, gaining access to savings that are already being enjoyed by other younger Americans.

Mr. WYDEN. I would only say to my colleague, I share your view about what a good managed-care program can do. It is just that what we are hearing that the insurers wring the savings out here. This really produces the savings. They can negotiate—Medicare Select insurers can negotiate to eliminate the part A deductible. And Mr. Pomeroy mentioned correctly that nobody else can. And I think it is one of the reasons that we need to work closely with you both, and I am anxious to do it so that this can go forward.

Mr. POMEROY. Other insurers do throughout the rest of the marketplace, the nonMedicare supplement marketplace. And my approach to this is different. Is this the silver bullet? The one-time fix we need for Medicare? Absolutely not.

I don't think you see many bills where the sponsors get up and say this is no big deal, which is essentially what Congresswoman Johnson and I have said. But does this run so afoul of public policy that it ought to be driven from the marketplace? I think it would be very hard to make that case.

Mr. WYDEN. My time is up. But I think both of you would agree, if what we are doing is playing a zero-sum game, where Medicare is facing a Draconian cut of upwards of $50 billion with all the things that are being taken off the table to get to the balanced

budget, that is what we are going to have to deal with if we are going to prevent a crisis this session in Medicare.

Mr. BILIRAKIS. Mr. Coburn.

Mr. COBURN. I just have one question.

We say this diagram of where large companies over 500 had a significant decrease in their cost. And I would propose to you that the main reason is because they were self-insured. They were sufficiently insured for the largest portion of that.

My question to you is if this is a cost savings and the Federal Government is the insurer through Medicare, why shouldn't the Federal Government share in some of the savings? We have increased benefits. We have pharmacy benefits. We have vision and eye care, some of the things that are not normally there. Why shouldn't the Federal Government share in some of the savings?

Mrs. JOHNSON. The current law requires that these insurers cannot reduce their price, but only can expand benefits to compensate for their savings. We need to change that so that there is more opportunity for government to share and seniors to benefit.

Mr. POMEROY. The other thing I would say is that as you have managed-care plans offering coverage to the senior population through MedSelect, utilization oversight will result in savings, medical savings. And that will enure both to HCFA and Medicare, taxpayers, as well as to the senior.

Mrs. JOHNSON. I am being reminded that my former statement is relevant to Medicare risk contracts, not Medicare Select, since Medicare Select is a medigap product. It is different.

Mr. COBURN. Okay. Thanks.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman.

I would like to focus a little bit on the rural aspect of Medicare Select. Medicare Select seems to give the option to seniors of either being in an HMO and using their participating doctors or paying a higher fee and using doctors outside the system.

Proponents argue that this is a good way to get managed care into rural areas. Michigan did not choose to participate because there was a lack of interest amongst the insurance companies and the only one—BlueCross/BlueShield was the only one that was interested in participating. And BlueCross has most of the doctors in Michigan signed up as participants in their plan.

Did you see an increase or decrease in participating physicians in Medicare Select? And I am also concerned Mr. Pomeroy, it must provide sufficient access. What does that mean?

In North Dakota this time of the year, or the upper peninsula, 10 miles cannot be sufficient access. And access is always going to be a problem in whatever kind of program we have.

Mrs. Johnson, I think, said it was 50 miles. That just wouldn't make it in our areas.

So I guess my concerns are access; do you see an increase or decrease of participating physicians; and I have a couple more questions if you could answer those two.

Mr. POMEROY. In North Dakota 73 percent—the Medicare Select is offered by BlueCross/BlueShield, 73 percent of North Dakota's physicians participate in that provider network and do agree to

take the Medicare Select product for that. They also agree to make Medicare on assignment, meaning they don't balance bill for charges over and above what Medicare allows, which is very significant.

Mr. STUPAK. So you don't have balance-billing in North Dakota?

Mr. POMEROY. No. And the question as to service, the service area has to be adequate to allow reasonable access and it also has to afford out-of-area coverage. I think the problem that you would find in the UP as well as North Dakota, is someone would be 200 miles from home and have a medical circumstance that required them to get coverage and that would be out of the provider area, perhaps. There is provision for out-of-area coverage.

Mr. STUPAK. Does North Dakota, or Mrs. Johnson, your State's use of this program, do they expand coverage at all? Do they expand if the husband is 65 and the wife is maybe 60 and not working, would she be able under Medicare Select to pick up coverage?

Mr. POMEROY. I don't think so.

Mr. STUPAK. Okay. Thank you.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman.

Nancy, I have only one simple question but I want to try to frame it just a little bit. As I understand it, Medicare Select is simply a program that we are trying in 15 States to see if the Federal Government can get Medicare into the managed-care market.

Now, if that is what we are doing, and today we are talking about expanding that to 50 States, if that is what we are doing, there are certain questions that I think we need to continue to ask and know the answer to before we decide to expand it any further.

For example, I think it is absolutely critical that patients have a choice, not just of managed care, but also fee-for-service care, which means medigap must come to play in that. Also, consumers must have an incentive in this to choose managed care if, in fact, managed care is going to serve for Medicaid, because they will never choose it without an incentive.

The cost of managed care, for example, must save money to the Federal Government. If it doesn't do that, then we don't need to be doing managed care for Medicaid.

And last, I have a question as to how long the deal lasts, I think those were your words—how long will the savings last. I know from experience that many of these HMO's will start up and offer everything under the sun.

Frequently, they don't last. There have been many statements about what our first responsibility here is, and to me, our first absolute responsibility is to evaluate the demonstration project. I cannot imagine moving it any further without doing that.

PPO's, managed care, may be adequate, but that is what it is. It is adequate compared to fee-for-service. Now, a country that owes $5 trillion perhaps should furnish adequate care.

I am not saying we shouldn't go in this direction and it is not the right direction. Medicare Select, in my opinion, should be extended for 6 months. And—you know, frankly, I would be glad to join you writing the bill to extend Medicare Select, and if HCFA

doesn't respond in 6 months, fire the 500 people over there. There is no excuse at all.

They haven't responded from the demonstration project. They are holding the thing up and they should be made to answer for that. But in the meantime, I want you to tell me what are the dangers if we simply just extend right now until we get all the answers prior to making this go into 50 States?

Mrs. JOHNSON. Well, first of all, this was a demonstration project. It has been a demonstration project for 3 years, and we have a lot of good information from that demonstration project, mostly from insurance commissioners who have tracked it very closely, and from other companies in the market who have tracked it very closely and who can report to you their participant's satisfaction rates, the rate at which people leave the program or give it up. And there is a lot of data on consumer satisfaction and on quality.

Mr. NORWOOD. Are those insurance companies that have been tracking it?

Mrs. JOHNSON. Insurance companies and insurance commissioners in overseeing the Medicare Select plans, so there is a lot of information. I don't know why HCFA has not been able to complete this report, but I can tell you that another 6 months won't make any difference. I want you to look at the material that we have available to address the issues that the report was supposed to address.

But I raise some other questions. You want to be sure that patients have a choice, that they always retain the choice of fee-for-service. They do absolutely. This does not to any smidgen compromise any Medicare recipient's access to fee-for-service medicine at any time. So they retain fee-for-service access.

Mr. NORWOOD. Do they have also access to medigap, which means that without that, many of them won't retain fee-for-service choice?

Mrs. JOHNSON. Absolutely. There are medigap policies in the market. This is one of them. If you buy Medicare Select, you also buy into a managed-care network and so your premium is much lower, sometimes no additional premium, because you are going to participate in the network. But you can leave at any time. You can go back to fee-for-service medicine at any time. You can go on to another medigap policy at any time. And the same rules that govern movement from medigap policy to medigap policy, govern movement from Medicare Select to medigap policy.

I would be happy to pursue this with you in detail. I think your questions are good but they are also answerable.

Mr. BILIRAKIS. I would like to announce in the interest of consideration for our future witnesses, we are going to break at 12 o'clock and come back at 1:15, so you can plan on that.

Mrs. Lincoln, your turn.

Mrs. LINCOLN. Thank you, Mr. Chairman, and thanks to you both for bringing such good testimony. I have one quick question that is on the heels of what Mr. Stupak was asking. I, too, have a predominantly rural district with an above national average number of elderly in that district.

His question basically was regarding access and availability in rural areas. Have you seen in North Dakota, perhaps in a similar situation with a rural area, an increase in availability because of the PPO or HMO enrollment that would ensure a certain amount of participants in an area? In fact, does it increase the availability in a rural area because you have an assurance of a certain amount of participants?

Mr. POMEROY. In light of the demographics of North Dakota that has a high percentage of elderly, similar to your district, I think that having seniors in a managed-care system helps give that system critical mass to work. In other words, have a sufficient number of insured to manage care at optimal efficiency within the insurance company.

That means you can manage care more specifically and more effectively and without having the senior population of 10,000 lives represented through Medicare Select in the BlueCross system. One could argue that the efficiency of providing managed care would be more limited.

Mrs. LINCOLN. I am interested to see if maybe you have seen any of that. We have seen 14 rural hospitals close in Arkansas over the past 5 years, largely due to the rate reimbursement, the lack of availability, and the problem of participants traveling into the larger urban areas because there is a lack of facilities in rural areas where they live.

So thank you for your testimony.

I yield back.

Mr. BILIRAKIS. The gentlelady's time has expired.

Mr. Burr.

Mr. BURR. Just one quick question for both of you.

In your opinion, has HCFA done an adequate job of alerting seniors to the option of Medicare Select and have they really done an adequate job of facilitating the program? I have heard the confusion over how long the assessment of the program has taken and I am just curious, have we given this a fair shake?

Mr. POMEROY. In my opinion, the HCFA role was to anticipate the end of the demonstration period and to have sufficient analysis at that time to let us know how it could be improved or whether it should be continued. I think they fell short there. And I think that they have left us in a situation where we—frankly, we jack companies around that have been providing it by saying, well, you almost expired last year and you almost expired before July 1, we will give you another 6 months.

It is a terrible way to try and establish a business. But under the circumstances, it is not at all fair to the private sector that stepped up to the plate to this program. And it could have been avoided if HCFA had acted in a more timely manner.

As a cosponsor in the last session and this bill, my discussions with HCFA began last week in terms of how this program could have been improved and that really was regrettable and avoidable.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. Deutsch.

Mr. DEUTSCH. Thank you, Mr. Chairman. And I apologize for being a couple of minutes late this morning. I look forward to the testimony.

In south Florida, the percentage of seniors that participate in this program is probably the largest in the country. We are talking in south Florida hundreds of thousands of people, and many of you know that before I got to Congress, and before I was in the State legislature, I was the Director of a Medicare Information Program in south Florida. So I have 15 years beneficiary perspective on Medicare and I think I have a very good understanding of how this program works in south Florida, and I have seen its benefit to hundreds of people I know personally, and in south Florida hundreds of thousands of people who are participants in this program.

And I agree with the last statement by Mr. Pomeroy, you know the 6-month extension at this point in time just seems like a crazy way to be running the system and I look forward to the testimony.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. Gentleman's time has expired, thank you. Mr. Whitfield.

Mr. WHITFIELD. I have no questions, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman.

I sort of echo the comments that you made in your opening statement. Of course, being from Florida we have a great deal of concern about this and it is a very popular program. I sponsored your bill last year, and I want to thank both of you for coming forward.

Mr. BILIRAKIS. Mr. Greenwood is not there?

Mr. Klug.

Mr. KLUG. Thank you, Mr. Chairman.

I wonder if I can briefly rise to the defense of the Medicare Select program. And I think one of the terrific stories we are going to hear is from Jo Musser, the Insurance Commissioner from the State of Wisconsin, wearing a different hat.

And I want to ask if perhaps what we have seen is problems in some parts of the country may reflect the maturity of the managed-care industry wherever those programs are located. And in the places that we have seen the most areas for concern, what we may really have is a variation of preferred providers, it is not a true managed-care environment. And if you look at places like Wisconsin or Minnesota or California, which have fairly well-developed managed-care systems and HMO models, we have actually had a great deal of success.

Would either of you agree with that statement?

Mrs. JOHNSON. I would absolutely agree with it. And I think if you make it permanent and in all States, in some States, it will grow and in other States, it will not grow in.

Mr. POMEROY. I agree, and I am pleased that Chairman Musser is Chairing the NAIC Medicare Select Committee. In Wisconsin, the experience is really optimal in terms of showing what this program can produce in terms of quality health care coverage to the enrollees but also savings to Medicare.

Mr. KLUG. I think we will hear from Commissioner Musser later on, but the experience in Wisconsin has been that senior satisfaction is high, the health care has been very good. And as I am sure Governor Thompson would tell you if he were here, there have been substantial savings to the State as well.

I thank you.

Mr. BILIRAKIS. All questions have expired for this great panel. We thank you so very much, and we plan to work with you on doing what is best for our Medicare beneficiaries.

The Chair would now call panel 2, which consists of Dr. Bruce Vladeck, Administrator of HCFA. You can proceed with your testimony and your written statement will be a matter of the record.

STATEMENT OF BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you, Mr. Chairman.

I very much appreciate the opportunity to be here today, and I have been busy trying to condense my oral statement to keep this as brief as I can.

I am very pleased to begin today a dialogue with this subcommittee about the current state of Medicare, and more importantly, its future. The members of this subcommittee have long played a central role in the Medicare program. You have an understanding of the vulnerable populations we serve and have contributed to major improvements over the years.

Medicare is a popular and successful program. I believe we need to work together to build on its successes and strengthen it for its beneficiaries and for the taxpayers who are its future beneficiaries. I believe we can work together to improve and expand managed-care choices in Medicare without substantially endangering the current program or compromising protection for beneficiaries.

We in HCFA have been working very hard to make Medicare an effective, affordable and customer friendly program. At the same time, we have been working on administrative program improvements that maximize the efficiency and cost-effectiveness of the program. I'd like to mention a couple of these briefly before speaking specifically about managed care.

Let me first begin by reminding you all of some of the characteristics of Medicare beneficiaries. There is a lot of mythology floating around these days about the elderly and their income and resources. But as you can see in chart 1, in 1992—and we had some criticism last week for using 1992 data as opposed to something more recent, but the basic pattern will not have changed—roughly, 83 percent of Medicare spending was on behalf of beneficiaries with incomes less than $25,000 a year.

The amount of disposal income of our beneficiaries is not that great. More importantly, the older and poorer the beneficiaries are, the sicker they tend to be.

If you will look quickly at chart 2, you will see that 20 percent of our beneficiaries are either 85 years or older—many of whom are women who live alone—or persons with disabilities, including end-stage renal disease. These are the fastest-growing categories of Medicare enrollment.

As you consider the future of Medicare, I urge you to consider these statistics. Without Medicare, millions of elderly and disabled Americans would not have health care coverage at all, let alone maintain the quality of life they now have.

Despite the size of the program, we continue to find very, very high levels of consumer satisfaction while keeping the administra-

tive cost at less than 2 percent of program outlays. As we expand choices for beneficiaries in the program, one of the issues we do need to continue to be concerned about is the trade-off within a pot of total dollars between administrative and managerial expenses, on the one hand, and medical services, on the other hand, where Medicare now compares favorably to even the most efficient private plans.

During the Clinton administration, projections for the average annual rate of growth for Medicare have decreased. We have benefited, although not to the same degree, as some of the private employers, by the deceleration in inflation in the economy as a whole, and particularly in the health care sector.

The President's fiscal 1996 budget projected a 9.1 percent average annual rate of growth. This is a reduction from the mid-session review 6 months earlier, when we were projecting growth in excess of 10 percent. This change is largely attributable to the decline in inflation in the economy as a whole, and particularly in medical care inflation.

As we move forward with the program, managed care will obviously be at the center of many of our discussions. We are committed to working with you to improve and extend the choices available to our beneficiaries so that they may have the full range of managed-care options that are available to the generally insured population.

The cornerstone of our policy is informed choice in a fair marketplace where beneficiaries have full and objective information and are not discriminated against on the basis of relative need. Currently, as Mrs. Johnson noted, 74 percent of our beneficiaries have access to managed-care plans and 9 percent are enrolled in managed care. In 11 counties, 40 percent or more of our beneficiaries are enrolled in managed care and more than 80 counties have enrollment levels at 20 percent or higher.

Medicare managed care is growing very fast. It has grown at a rate greater than 1 percent a month for the last 18 months, reaching 16 percent in the year ending January 1994. More importantly, the number of risk contracts we are signing is growing faster than the number of enrollees. That number increased 20 percent. Five States that previously had no Medicare HMO's signed up last year.

Mr. BILIRAKIS. Could you summarize, please?

Mr. VLADECK. Let me talk briefly about Medicare Select.

We believe that the fastest-growing and most popular option for managed care in the private sector is not HMO's but preferred provider organizations or PPO's. Select gets you part of the way down the road, but we would very much like to work with this subcommittee and the other committees of jurisdiction in the Congress to give Medicare beneficiaries a real PPO option, similar to what is offered in the private sector.

In that regard, we think that the expansion and long-term status of Select has to be addressed as a halfway measure in the direction of PPO's, which neither in terms of savings to the government, nor in terms of real management of care, gets us where we need to go. And we would like to talk with you and all of your colleagues in that context about the future of Select and the more important option of a real PPO in Medicare.

I am happy to respond to any questions.
[The prepared statement of Bruce Vladeck follows:]

PREPARED STATEMENT OF BRUCE VLADECK, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and members of the subcommittee: I am pleased to be here today to begin a dialogue with this subcommittee about the current state of the Medicare program and, more importantly, about its future. The members of this subcommittee have long had an understanding of the complexities of the Medicare program and the vulnerable population that we serve, and have contributed to major improvements in the program over the years. Medicare is a popular and successful program. I believe we need to work together to improve on the program's success and strengthen it for its beneficiaries and the taxpayers who support it.

We in HCFA have been working very hard to make the Medicare program an effective, affordable and "customer friendly" program for beneficiaries. At the same time, we have been working to implement administrative and program improvements which maximize the efficiency and cost effectiveness of the program. I want to begin by reviewing some of our recent efforts and successes and then provide you with an overview of our efforts in the area of managed care. Finally, I would like to discuss some of our initiatives to improve the administration of the Medicare program.

Medicare is the world's largest health insurance program and by many measures one of the most successful. It began in 1966 as a Federal health insurance program for the elderly and was expanded in 1972 to cover disabled persons and those with End Stage Renal Disease (ESRD). The Medicare program was established because our vulnerable populations had difficulty obtaining private health insurance coverage.

Medicare is administered largely by private contractors under our supervision. In 1994, Medicare served almost 36 million persons under parts A and B of the program. Aged Medicare beneficiaries number 32 million, 3.6 million are disabled and 77,000 have ESRD. Medicare has agreements with over 65 contractors to process beneficiary claims. In FY 1994, over 750 million claims were processed and Medicare paid more than $159 billion for medical services, treatment and equipment.

Today, we maintain Medicare's commitment to serve the most vulnerable. Medicare is the largest payor of the elderly's health care expenses. As the subcommittee examines the future of the Medicare program, I would urge you to consider the following important facts about Medicare beneficiaries.

—Relatively few Medicare beneficiaries can be considered financially well-off. Approximately 83 percent of program spending in 1992 was on behalf of those with incomes less than $25,000. (CHART 1)

—Currently, 20 percent of our beneficiaries are either seniors age 85 and older, most of whom are women, or persons with disabilities including End Stage Renal Disease (CHART 2).

—Third, per capita health care spending for aged beneficiaries is 4 times the average for the under 65 population.

Medicare is successfully fulfilling its mission and beneficiaries continue to express a high degree of satisfaction with the program. Millions of elderly and disabled Americans now have health care coverage and a quality of life that they would otherwise lack, thanks to the Medicare program.

Despite the size of the Medicare program, we have maintained a high level of consumer satisfaction with low administrative costs, less than 2 percent of program outlays. In contrast, private insurance administrative expenses are about 25 percent in the small group market and about 5 percent in the large group market.

Medicare has been a pioneer in streamlining program administration and is a world leader in fostering electronic claims submission: 90 percent of Medicare's hospital and skilled nursing facility claims and 67 percent of its physician claims are submitted electronically. In contrast, 60 percent of Blue Cross' hospital claims and 20 percent of its physician claims are electronically submitted. For commercial carriers, the percentage is 10 percent for all claims. (CHART 3)

We have focused attention on reducing the paperwork burden on health care providers, working closely with the health care community to establish a standard uniform national Medicare claim form for physicians and another for hospitals, Skilled Nursing Facilities (SNF's) and Home Health Agencies (HHA's). Many other insurers use these forms, but attach additional forms as well. These, however, are the only hospital and physician claim forms that Medicare requires.

During the Clinton Administration, the projections for the average annual rate of growth for Medicare have decreased. In the President's fiscal year 1996 Budget, the

projected annual average rate of growth for 1996-2000 is 9.1 percent. In contrast, 6 months ago in the Mid-Session Review, the projected annual average rate of growth for the same period was 10.3 percent. The primary contribution to lower Medicare projections is slower growth in Part A Hospital Insurance expenditures. The decline in projected Part A growth results primarily from a decrease in forecasted hospital cost inflation and slower growth in the complexity of Medicare inpatient cases.

Today, any discussion of the quest to enhance cost effectiveness, as well as the accessibility of quality medical care for beneficiaries, must include managed care. We are committed to working with you to improve and extend the managed care choices available to our beneficiaries so that they have the full range of managed care options available to the general insured population. The cornerstone of our policy is informed choice in a fair marketplace, in which beneficiaries have full and objective information and are not discriminated against on the basis of relative need.

Managed care is not a new concept for the Medicare program. Since its inception in 1966, a portion of Medicare beneficiaries have received care through managed care arrangements. Enrollment is increasing, and we anticipate continued strong growth as newly entitled beneficiaries, who are more familiar with managed care, enter the Medicare program.

Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option. 1994 was a year of impressive growth in Medicare managed care, we experienced double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

As we work to extend and broaden managed care options for Medicare beneficiaries, we must be aware both of the practical limitations of a rapid expansion of managed care in Medicare and of past failures of overly aggressive efforts in both the Medicare and Medicaid programs. The movement to managed care cannot outpace the capacity of managed care plans to serve large numbers of new enrollees, particularly those with the expensive and special health needs of the Medicare population.

In addition, for Medicare to benefit from the expansion of managed care, we need to improve the way Medicare pays managed care plans. Managed care currently costs the Medicare program rather than achieving savings. Our evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that they attract the healthier members of the Medicare population whose health care costs are lower. Efforts are underway to improve the current payment methodology so it doesn't act as a barrier to the expansion of managed care. We have initiated several research projects and demonstrations to address this situation and we expect to have preliminary results later this year.

Medicare beneficiaries themselves must determine the pace of their movement to managed care. The emphasis must be on choice. Managed care will succeed as managed care plans are able to prove the value of their products and as beneficiaries recognize the benefit of the coordination of care and case management that high quality managed care plans can provide.

Experience with Medicare SELECT should be part of our efforts to improve current managed care options under Medicare. We believe, however, that any expansion of SELECT should be preceded by a serious examination of our experience under the 15-State demonstration. We have looked at this experience and have two areas of concern.

One major concern is with the adequacy of beneficiary protections under Medicare SELECT. There is no requirement for States to review the actual operations of the SELECT plans once they are approved to assure that quality and access standards are being met. We feel strongly that beneficiaries should not have to worry about the quality and access provisions of their Medicare choices. We look forward to working with the subcommittee on this important issue.

Our second concern is whether Medicare SELECT will make any contribution to increasing the efficiency of the Medicare program. As you know, Medicare SELECT

was designed to create a hybrid of managed care and Medigap that would be beneficial both to beneficiaries and to Medicare. Our experience under the demonstration, however, is that plans generally achieve savings for beneficiaries through hospital discounting arrangements rather than the active management of care or the efficiency of the SELECT networks. More than half of the current SELECT plans are hospital only networks. We believe that such plans do little to contribute to the increased efficiency of the Medicare program and the Congress should understand this as it considers making the SELECT program permanent. Some advocates of SELECT have proposed to expand the discounting arrangements to Part B services. We would oppose such a modification since it would actually increase Medicare costs, as physicians increase utilization to recoup their discounts.

Given the impending deadline for the expiration of the authority for Medicare SELECT demonstration and the need to examine the demonstration experience, the Congress may want to consider a quick extension of the demonstration for existing plans through the rest of the calendar year. This 6-month extension would address the current uncertain state of the existing Medicare SELECT plans and provide ample time to examine the experience under the demonstration and to determine the changes to SELECT that should be made based on demonstration experience.

We want to make available to beneficiaries a new preferred provider organization (PPO) option. This option has proven to be very popular in the commercial market, and many of us have access to PPO's. We believe that Medicare beneficiaries should have the same range of choices. Under the PPO option, would face nominal copayments if they stayed in plan but would have the option to go to any physician at any time, if they were willing to pay the cost-sharing.

In developing a PPO option for Medicare, we hope to learn from our experience with the Medicare SELECT demonstration. Medicare SELECT plans have limited incentives to manage total costs. Under the PPO option, plans would be at some risk for Medicare benefits. Our objective is to ensure the same quality, access, grievance and appeal procedures as we do now in Medicare risk and cost plans. We hope to be able to work with the subcommittee on the PPO option in the months ahead.

We need to do a better job of informing beneficiaries about the managed care and Medigap choices that are available. The current lack of information in the face of such a variety of choices generates confusion which works against managed care options. To understand their choices, beneficiaries have to negotiate through differences in benefit packages, cost-sharing structures and premium amounts. Beyond this need for information, beneficiaries are also be faced with enrollment periods that vary by plan and, in the case of Medigap, with health screening and underwriting. Beneficiaries who initially enroll in a managed care plan lose their one time option for open enrollment in Medigap.

We would like to do everything possible to make managed care options very attractive to beneficiaries. We think we can do a better job of helping them to understand the advantages of these plans.

Today, managed care organizations providing services to Medicare and Medicaid beneficiaries are required to have internal quality assessment and improvement programs to identify ways to improve the delivery of health care services and the health care itself. We also require independent external review of quality of care delivered to our beneficiaries.

HCFA is working in collaboration with the industry on a long term effort of developing a single set of measures that could be used by all payors to address the full range of a health plan's membership and performance.

The first phase of this effort centers on major performance measurement projects underway in both Medicare and Medicaid. These are designed to help us develop measures that are focused on the special needs of our diverse populations.

In Medicaid, we are working collaboratively with National Committee for Quality Assurance (NCQA), State Medicaid agencies, consumer advocates and managed care organizations to adapt the commercial sector's state-of-the-art performance measurement tool HEDIS (Health Plan Employer Data and Information Set) to the needs of the Medicaid program.

We chose HEDIS as the template for our Medicaid effort for several reasons:

—HEDIS is viewed by most of the leading state managed care programs as the appropriate model for Medicaid. Some States are already adopting HEDIS. We feel it is important to provide some national leadership.

—We want to coordinate with the private sector and take advantage of the significant analytical groundwork already produced by NCQA, so as to minimize potential reporting burdens on our managed care plans, many of which are adopting HEDIS.

In Medicare, we are beginning to pilot test a new, performance based approach to Peer Review Organization (PRO) review of HMO's developed under contract with the Delmarva Foundation. These measures reflect the special health needs of an el-

derly and disabled population, for example, in management of chronic conditions. These measures will then be considered in conjunction with the broader HEDIS effort.

As I discussed above, concerns about the payment methodology for risk contractors has been long standing. Currently, we determine rates on a yearly basis, and plans decide whether or not to enter into a contract each year based on the rates. These rates, called the Adjusted Average Per Capita Cost (AAPCC), are developed for each county and are based on fee-for-service costs in the area. County rates are then adjusted for age, sex, institutional and Medicaid status; no adjustment is made for health status per se. Plans have been concerned with the adequacy, stability and equity of the AAPCC. Early on, when I became Administrator of HCFA, I invited the industry to come up with alternatives to the AAPCC. We still have no significant alternatives.

One concept that has recently received widespread support and attention from industry, academia and commercial payers is that of "competitive bidding." Proponents of competitive pricing models claim that the methodology will result in payments that more accurately reflect the true costs of doing business, in addition to promoting efficiency through greater competition among health plans.

We think that this is a promising idea, and we would like to test variants of it as demonstrations in a number of geographic areas. In order for the demonstrations to be useful, we believe that competitive bidding should become the payment methodology for all Medicare managed care plans in the demonstration areas. As always, beneficiaries will still have the ability to choose to enroll in managed care plans or remain in fee-for-service. We would be interested in working with the subcommittee on the structure of a competitive bidding demonstration.

Managed care options, while of growing importance to the administration of the Medicare program, are not the whole story. We are actively working to improve management throughout the program and to make continued innovations in the fee-for-service program.

Under the leadership of President Clinton, Vice President Gore and Secretary Shalala, we at HCFA have focused our efforts on making sure that our nearly 70 million beneficiaries (Medicare and Medicaid) receive the health care they need when they need it. This means that beneficiaries come first in all that we do. HCFA has undergone significant internal and external changes to ensure that the "customer first" philosophy becomes a reality. Throughout the agency, we are working to improve communications with beneficiaries—whether it be one-on-one in person, on-line through the computer, over the telephone, through our numerous publications or through the media.

The nature of the Medicare program is such that there are numerous other people and organizations that have closer contact with beneficiaries than HCFA. They are also our customers and our partners in providing health care services—providers such as hospitals, nursing homes, home health agencies, physicians and medical suppliers; contractors (carriers and intermediaries) that process and pay Medicare claims; and, Peer Review Organizations that assure the quality of health care services.

We have developed a set of customer service standards that apply to our interactions with beneficiaries and our partners. These standards apply to all of our communications, claims processing activities, customer satisfaction, consumer choice, health care quality and program administration. For example, we are working with our customers to make our publications and notices easier to understand. We are simplifying Medicare claims administration so that claims determinations will be more consistent. We are placing a premium on measuring and improving customer satisfaction through the use of surveys, focus groups and meetings.

We also believe that the need for integrating delivery systems will become more and more critical as our population becomes increasingly diverse and older with more chronic care needs. In order to meet these needs, it is clear that HCFA must maintain a collaborative relationship with its partners in the provider community and assist them to improve their focus on customer service. Several such initiatives are already underway. HCFA is examining all of the long-term care services provided by both Medicare and Medicaid and is considering ways that these services can be better coordinated with one another and with the acute care system. A similar review of home health care programs has also been undertaken.

Starting at the Office of the Administrator and at every level of HCFA, we have expanded and strengthened our efforts to root out fraud and abuse against Medicare and Medicaid and to vigorously pursue those who commit such illegal activities. We operate in a partnership, not only with the Department's Office of the Inspector General, but with the Department of Justice, including the FBI, state and local law enforcement agencies, and our contractors. Further, HCFA is increasingly exercising

its authority to suspend payments to providers and suppliers when evidence of fraud exists.

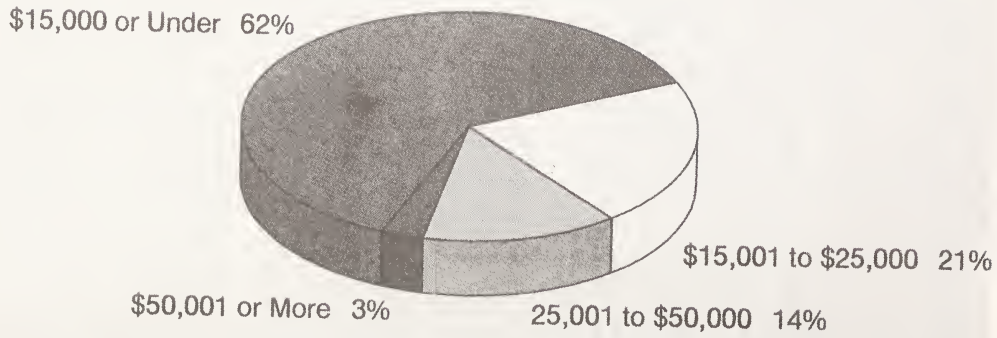
In addition, HCFA is reviewing and changing programs and policies that have been found most vulnerable to abuse. For example, in order to better monitor fraud and abuse related to durable medical equipment (DME), HCFA has changed the procedures for claims processing. Four carriers are now responsible for DME claims processing rather than the previous 33 carriers, a system which provided DME suppliers opportunities to submit claims to the carrier whose payment policy was most liberal. The new system of using four regional carriers reduces the chance for fraudulent billing because suppliers must submit claims to the carrier in the region where the beneficiary resides.

The use of more sophisticated data processing systems, such as the MTS system, that I discussed earlier, further increases the chances of detecting aberrant patterns that might indicate abusive behavior. The MTS system will greatly improve HCFA's ability to screen Medicare claims for errors and fraud.

For 30 years, Medicare has been insuring the Nation's elderly and disabled. We know from our focus groups, and I think you are all aware from interactions with your constituents, that beneficiaries feel a certain ownership of the program. This feeling is justified. We want to work with you to make responsible decisions in planning the next steps for the future of the Medicare program. We look forward to working with this subcommittee as we expand choices available to beneficiaries without compromising quality, access or value.

Share of Program Expenditures by Income

Of Medicare Individuals or Couples, 1992

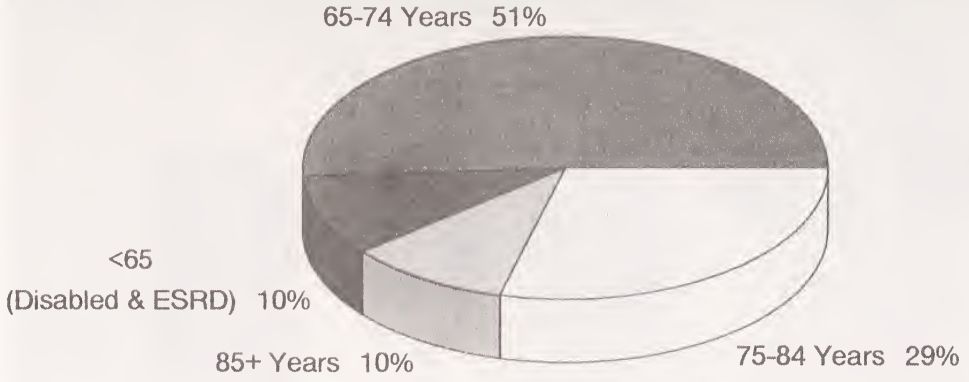


83% of Expenditures: Annual Income of $25,000 or Less

Excludes 2.2% not reporting income.
Also Excludes HMO enrollees (9%).
Source: HCFA/OACT

The Composition of the Medicare Population, 1992

Elderly, Disabled and ESRD



Total Beneficiaries=35.6 Million

Source: HCFA/BDMS

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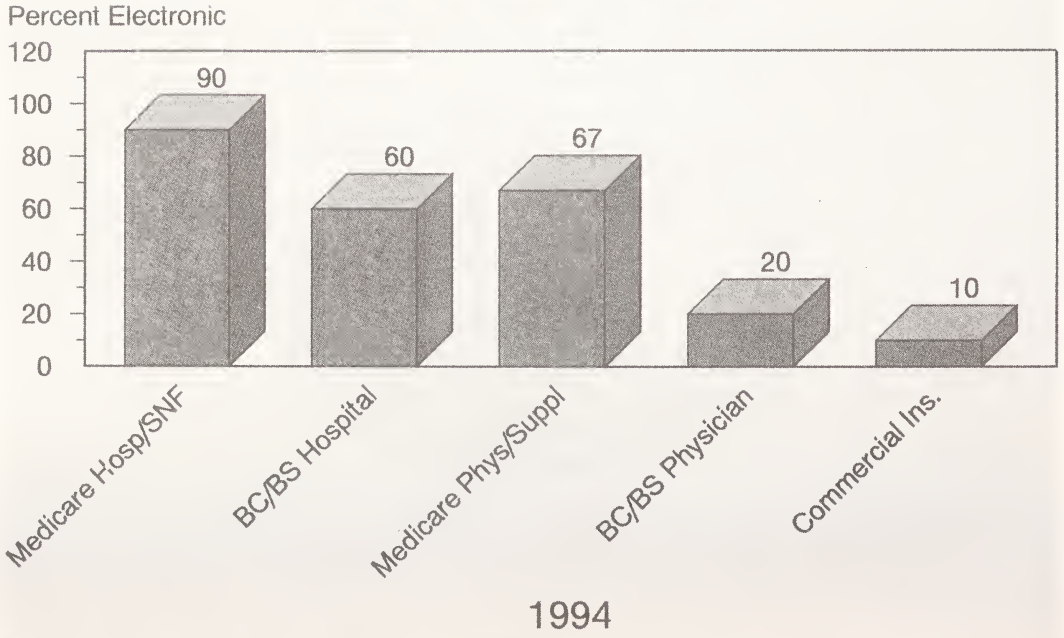
Electronic Submission of Claims

Medicare vs. Private Insurance



Source: HCFA/BPO; Blue Cross Assoc.

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Mr. BILIRAKIS. Thank you.

Doctor, you certainly have a tough job.

Could you compare for us the current regulatory standards for quality and access in HMO's and in the Medicare Select program, and use all 5 minutes if you would like? I think it is very significant.

Mr. VLADECK. Yes, sir, there are three major differences. In terms of access, the National Association of Insurance Commissioner Standards, which the 15 States have adopted, require plans to demonstrate the adequacy of their provider network when they first apply for Select status in the demonstration States. This is mostly done by submitting a description of the network, and the preliminary report by the evaluator suggests that it is monitored, to a limited extent, in most of the States in which Select plans are operating.

On the other hand, under Medicare HMO rules, plans have to provide us on a continuing basis with actual data about utilization, about how quickly phones are answered and how quickly appointments are made, which permit us to monitor actual access to care rather than theoretical access.

Select plans must describe their quality assurance plans. In some States, the evaluation shows the actual operation of those plans are monitored by the State insurance departments or the regulatory agencies. In other States, they are not monitored once the plan is approved.

Medicare HMO's are required to have an external, independent physician body review a sample of the medical care provided in Medicare HMO's; this is not required in Select plans. I think those are the most significant differences.

Mr. BILIRAKIS. Thank you, doctor.

Doctor, many health policy experts believe that when managed care captures a substantial portion of the health care marketplace, it exerts a competitive-cost containment affecting the entire health care marketplace. HCFA data shows, as I understand it, that in metropolitan areas where Medicare risk enrollment averaged 25 percent, the annual growth rate in Medicare fee-for-service costs was 2 percentage points lower than in metro areas where the Medicare enrollment was minimum. Don't you agree that Medicare fee-for-service costs are solved by the competitive pressures of Medicare managed-care options?

Mr. VLADECK. This is an issue that I have looked at over a number of years from a number of different professional vantage points, and would have to say that there are enormous variations in costs from one area to another, and many things have been offered as explanations. We have communities that are low cost to the Medicare program, with no HMO penetration. We have communities with high HMO penetration that are very high cost. In a couple of those communities, growth rates have been lower because the costs were so high to begin with. So it is very hard, within the Medicare program, to attribute significant savings in our fee-for-service costs to managed-care penetrations in those markets.

Mr. BILIRAKIS. Your recommendation is that there be an extension limited to 6 months; is that correct?

Mr. VLADECK. We would be willing to talk about such an extension. We would like to work toward making the program better, by making some improvements in it that have been suggested in our written testimony or by addressing some of the questions that the members have asked. And what needs to be done in the interim, frankly, is a question of the legislative timetable and the feasibility of getting a bill through in time.

Mr. BILIRAKIS. When would we likely see the results of your study that was due last month?

Mr. VLADECK. The study will not be done until later this year, and I would be happy, if you wish, to give some more information on why the timing of the study is the way that it is.

Mr. BILIRAKIS. I don't want to take any more time because I know that you have to leave and I want the others to have the opportunity to pose their questions.

Thank you, sir.

Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. Vladeck, is it your testimony that current Medicare managed-care programs cost rather than save the government money?

Mr. VLADECK. Yes, sir.

Mr. WAXMAN. Would you explain?

Mr. VLADECK. Well, our payment method is an effort to estimate 95 percent of the costs of an analogous patient in a fee-for-service system in the same county as the HMO, and it adjusts for age and gender, disability status, and a few other predictors of health utilization.

But relatively systematically the beneficiaries who go into HMO's are healthier than the beneficiaries who don't. And thus, at 95 percent of the average cost in the fee-for-service sector, we are actually paying more than it costs the HMO's to provide those patients with care and keeping the more expensive patients in the fee-for-service side of the program.

Mr. WAXMAN. If we are going to get to a balanced budget, we are certainly going to have to look at reductions in Medicare expenditures. What does our experience tell us about whether expanded participation by HMO's and beneficiaries in the managed-care programs will result in savings to the government?

Mr. VLADECK. We are working hard to improve our payment methods. If and when we do, we can look at some of the experience that has been cited by GAO or CBO about managed care, or some of the longer-term experience in the private sector, which shows savings over time of 5 to 10 percent by moving a healthy, younger population from fee-for-service to managed care. We have never demonstrated similar savings in the Medicare program. And in the long-term, given the kinds of numbers of people we are talking about, that seems to me to be relatively modest savings.

Mr. WAXMAN. When we have finished talking about all the possible restructuring of Medicare in order to achieve expenditure reductions at the Federal level, aren't we really talking about cutting the payments to providers, cutting the benefits, providing fewer services, or asking the beneficiary to pay more out-of-pocket?

Mr. VLADECK. Mr. Chairman, as you know, since January of 1993, the President has made it very clear that he believes that the

long-term financial well-being of Medicare is critically and inextricably tied to a more general reform of the health care system. It is very hard to reduce costs of one piece of the system at a time when other parts of the system have such severe problems that are not being addressed. And as events have played out over the last couple of years, that seems to be ever more the case.

Mr. WAXMAN. Does that mean if health care costs are out of control generally, we are going to have to either pay what the market is requiring us to pay in order to buy those services or if we compress what we pay, it is going to shift the costs on to the private sector?

Mr. VLADECK. Or worse, it could result in deteriorations in access or quality for Medicare beneficiaries.

Mr. WAXMAN. Or both?

Mr. VLADECK. Or both.

Mr. WAXMAN. Unhappy prospects.

Thank you.

Mr. BILIRAKIS. Dr. Ganske.

Mr. GANSKE. I am looking over the list from the Medicare Select list of States, and I have two sets of data. I think I have one that was provided by Congresswoman Johnson and one from HCFA that is a year old. But when I look over participation levels, I see Arizona, 1,500 patients; Illinois, no patients; Indiana, 1,500 patients; Massachusetts, no patients; Missouri, 5,000 patients; North Dakota, 10,000; Ohio, none; Texas, 8,000; Washington, none; Wisconsin. If you go down this list, it looks like about 9 out of 16 States have fewer than 10,000 patients enrolled in these plans. Is that accurate?

Mr. VLADECK. As accurate as of very recently. Yes, it is accurate.

Mr. GANSKE. In your opinion, is it possible to get an adequate study out of a State that has maybe 100 patients enrolled in a plan?

Mr. VLADECK. No, sir.

Mr. GANSKE. I asked Congresswoman Johnson, and indicated I would ask you this question, too. Why can't we get a more timely report on this pilot program?

Mr. VLADECK. I think the basic issue is that most of these plans, unless there was a preexisting insurance arrangement that got renamed as Select after the law was passed, did not get up and running until the latter part of 1992. As a result, this is a market that is at its very early stages in most States.

Most Select enrollees are in four States. In three of those, Alabama, Wisconsin, and California, there were considerable people in analogous plans before the legislation was enacted. So your tradeoff in evaluation is whether you do it before the market has had a chance to respond to the new set of rules at the risk of getting distorted results, or waiting until some of these firms are out there selling in the market, which creates problems in the timeliness of the evaluation.

I guess my predecessors guessed a little bit wrong in terms of the timing of that, but the original law called for the demonstration to run through December 31, 1994, and for the report to be transmitted to Congress in 1995 on January 1, a rather heroic assumption.

Mr. GANSKE. Do you see a danger to simply giving a 6-month or year extension to this pilot program and coming back and reevaluating your report?

Mr. VLADECK. No, sir. I don't see a significant danger.

Mr. GANSKE. Do you see a danger in going ahead and authorizing all 50 States to participate in this program?

Mr. VLADECK. If we were to do that, there might well be a significant missed opportunity. That is to say, there are a lot of anecdotes and theoretical concerns about the program. I think Mrs. Johnson and Mr. Pomeroy are quite correct that many of these concerns are not yet supported by a significant amount of data. If we waited until we had much better data before extending it to the whole country, we might avoid a serious mistake or find a way to significantly improve the program.

Mr. BILIRAKIS. What period of time are you suggesting when we might have better data?

Mr. VLADECK. Again, I think it will probably be the third quarter of this year at the earliest, pushing the evaluators as hard as we can, before we can begin to get the comparative cost and utilization analyses between Select enrollees and other participants, which is critical to the evaluation.

Mr. BILIRAKIS. Mr. Wyden.

Mr. WYDEN. In response to Mr. Waxman's question with regard to HMO's and savings, I heard you say that it would be necessary in order to get savings to retool the payment system in HMO's. Are you saying that in order to get savings, it would be essential to pay health maintenance organizations less than they are getting at present?

Mr. VLADECK. Not precisely, sir. I think it would be necessary to pay them more equitably in a way that is more attuned to the characteristics of the individual enrollees.

Mr. WYDEN. Well, I hear my colleagues saying that the health maintenance organizations are going to be the silver bullet and that somehow you are going to be able it save these vast sums over the next 5 years as a result of health maintenance organizations. And I just don't see it. And particularly with the kind of subtleties that you are talking about in terms of retooling the payment system, it is pretty clear to me that if you are going to make a massive cut in Medicare, as their budget plans envisage, you are not going to save that money by putting people in managed care unless you are going to, in effect, cause serious injury to seniors. And I appreciate that answer.

At the hearing I held in December, the General Accounting Office gave, in my view, as blistering indictment of the administration of your program as I ever heard. But they said point blank, that Medicare today denies senior citizens claims that ought to be paid; pays claims that ought to be denied; and that the government doesn't have a system for rationally distinguishing between those two kind of categories. What is your response to what the General Accounting Office said in December?

Mr. VLADECK. As you know, Mr. Wyden, we would strongly disagree with the notion that we don't have a rational system for reviewing claims. We would acknowledge that system is driven to a considerable extent by very serious constraints on the budget for

management of the program that have been in place for a number of years and that permit us the funds to manually review only a small proportion of all claims.

As we discussed at the hearing in December, the administration will be bringing forward a proposal in the next couple of months to address the financing of program integrity activities in the Medicare and other benefit programs. And we will be speaking to that.

Mr. WYDEN. I look forward to seeing it. I will tell you that I think throwing money at the current system, when you basically have got 34 insurance companies off doing their own thing, is a mistake. And I just hope that you all, as you talk about requesting more money to deal with program integrity, will look at what the General Accounting Office said, because I think it was as blistering indictment of a program as I have seen.

And certainly having been involved in this program since my days with the Gray Panthers, we never had the government saying that claims are being denied that ought to be paid and vice versa, and I think it has got to be addressed.

Mr. BILIRAKIS. Mr. Coburn.

Mr. COBURN. I have a couple of questions.

What is the total budget for HCFA for managing Medicare?

Mr. VLADECK. The total budget for managing Medicare and Medicaid and our other activities in the current fiscal year is approximately $2.2 billion.

Mr. COBURN. And that includes the money that is paid for other people to manage Medicare as well?

Mr. VLADECK. $1.6 billion of that is payments that we make to the Medicare contractors who actually pay the claims.

Mr. COBURN. So what is the total cost of everything that this government spends in managing the health care programs in this country? What is the total cost? Is it not much more closer to $8 billion?

Mr. VLADECK. If you talk about Medicare and Medicaid, and if you talk about the Federal budget, the only dollars that are not included in that total are some of the funds that are paid to the Social Security Administration for the initial eligibility determination and information distribution as we enroll Medicare beneficiaries. In terms of other Federal Government programs in health care, those are not part of HCFA's activities and not part of our budget.

Mr. COBURN. If we exclude end-stage renal disease and the disabled, what is the per-patient cost for Medicare in this country?

Mr. VLADECK. I believe last year it was about $4,200 or $4,300 per beneficiary.

Mr. COBURN. And what is the per-patient cost, do you have any idea what the per-patient cost is for a veteran?

Mr. VLADECK. No, sir, I don't.

Mr. COBURN. And how about for somebody who is not Medicare and not a veteran?

Mr. VLADECK. The data that was reported earlier this week about the private sector is running, depending on what part of the country you are in, as I understand it, $3,300 to $3,800 per year.

Mr. COBURN. Per person?

Mr. VLADECK. Per person. Now, there is real apples and oranges problems with these comparisons. On the one hand, our folks are

much older and sicker. On the other hand, most private insurance benefit packages are much more generous than Medicare.

I believe Mary Lehnhard has done some charts attempting to estimate the relationship between per capita costs and adjusting for those differences. I don't have them available, but we can try to get them to you.

Mr. COBURN. Having set the stage that there are several billion dollars being spent for managing Medicare and Medicaid, can you answer for me what you think the total dollar amount is in terms of fraud and abuse that is in the Medicare system?

Mr. VLADECK. The previous Inspector General of the Department and others have often cited—counting abusive activities as well as fraudulent illegal activities—a number in the range of 10 percent of program outlays.

We believe that if we could put a more precise quantitative estimate on that, we would prove that we are doing an adequate job deterring it. If you know that there is still crime out there, then you are not successfully catching all of it; we believe it is in the many billions of dollars.

Mr. COBURN. Translate that many to a number.

Mr. VLADECK. Ten percent of total Medicare and Medicaid outlays, if you include State outlays, would be $30 to $40 million per year.

Mr. COBURN. And we are talking about trying to control the cost of the system and we are trying to do everything except correct the fraud and abuse. And I guess my question to you is as a part of this Medicare Select program we seem to be concentrating in the wrong area. And going back to my opening statement, we have designed a system that is set up for fraud and abuse. And as long as we have a system that is set up that way, you are going to have it. And I think the charge ought to be to HCFA to change the system and the Congress to change the system to where we take advantage of our positive qualities rather than our negative qualities.

Mr. BILIRAKIS. The gentleman's time has expired.

I might ask, does HCFA have any recommendations toward that end?

Mr. VLADECK. As I suggested briefly earlier, we are coordinating our proposals with the Inspector General and with the Department of Justice and others. Within the next 60 days we will have a major proposal for you on fraud and abuse in all of the HHS programs.

Mr. BILIRAKIS. Will you make those available to this committee?

Mr. VLADECK. As soon as they are available, we will make them available to you.

Mr. BILIRAKIS. Within 60 days.

Mr. VLADECK. Yes, sir.

Mr. STUPAK. Thank you, Mr. Chairman.

I don't mean to oversimplify this issue or anything like that, but the short time I have sat here I get the distinct impression that the success of this program really depends upon the State insurance commissioner's rules and regulations for that particular State.

Like Mr. Pomeroy talked about no balance billing in the State of North Dakota, in Michigan we tried that and we could not get it done legislatively. It seems to me that the whole process depends

upon the rules and regulation of the State and how it is applied there. Is that oversimplification?

Mr. VLADECK. Yes, sir. I think it is true that there is considerable variation between the States in what the Select program is like and how the State governments oversee them and regulate them.

Mr. STUPAK. Thank you.

No further questions.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Norwood.

Mr. NORWOOD. Thank you, Mr. Chairman.

This, of course, is not a hearing about whether our constituents like Medicare or not. I think everyone knows that they do. However, the Medicare Select program seems to be heading everyone toward managed care. If we head all of our patients into managed care, would that save the government money?

Mr. VLADECK. I don't know, sir.

Mr. NORWOOD. Who does know?

Mr. VLADECK. I don't know that anyone knows. In order to have all Medicare patients in managed care, you would need so significant a change in the structure—not only in the rules of the program and the benefits, but in the managed-care marketplace—that you are into several levels of hypotheticals, and I just don't know the answer.

Mr. NORWOOD. Was not this demonstration project an effort to try to determine if managed care would save us money?

Mr. VLADECK. While I wouldn't characterize the objectives completely of the original sponsors of this proposal, I believe their aims were somewhat more modest. I thought in a world in which more and more of the private health insurance market is going to PPO's that are neither HMO's or fee-for-service, there was a desire to introduce a PPO product in the program.

Mr. NORWOOD. Don't we need to know—if we are going to an adequate care system versus a superior care system, don't we need to know whether it would save us money?

Mr. VLADECK. Well, I believe, sir, that the first principle ought to be that beneficiaries have choices as to how they get their care. Some folks prefer managed-care arrangements. After that, the extent to which we promote these should certainly be connected to our ability to expect savings. Yes, sir.

Mr. NORWOOD. The only people who choose managed care are people when you take dollars out of it. If you give them the choice of fee-for-service versus managed care and don't have dollars involved in it, they are going to choose fee-for-service. So the idea here is to try to save this government money so we can continue to have Medicare and afford it. And I don't understand why this demonstration project isn't leading us toward understanding that.

Mr. VLADECK. Well, we believe it will help, sir, but not perhaps as quickly as some of the advocates of the program would like.

Mr. NORWOOD. OBRA 1990 requires the Secretary to conduct an evaluation of the Select demonstration program and submit the results to Congress by January 1, 1995. Have you done that?

Mr. VLADECK. No, sir.

Mr. NORWOOD. Are you breaking the law?

Mr. VLADECK. I guess we are, yes.

Mr. NORWOOD. Thank you.

Mr. BILIRAKIS. Doctor, do you have to leave right at 12?

Mr. VLADECK. No, I do not. I hoped to communicate to you that I am available for a while longer.

Mr. BILIRAKIS. What we are going to do is break for this vote, which some of us may miss anyhow, and either I or Mr. Greenwood will take the Chair, and then we will break until 1:15.

Thank you very much doctor.

Mr. VLADECK. Thank you, sir.

[Brief recess.]

Mr. GREENWOOD [presiding]. The hearing will resume.

Since I am the only one here, I think I will recognize myself.

I would like to raise an issue that is not what we are essentially focused upon but it bears an important relationship. Yesterday, I met with the leaders of Pennsylvania's six academic health centers, the heart and soul of health care in our State, and certainly major contributors to health care in the country. They raised their concerns about the ability of academic medical centers and large inner-city providers to compete in the managed-care arena.

Their ability to compete is directly related to the recognition that Medicare reimbursement rates include reimbursement for the costs of their special mission—teaching, care for the indigent, and research. One of the concerns that they expressed was that under the regime of managed care, the additional payments that they are to receive for these services go not directly to them on a fee-for-service basis, but through the managed-care programs. They are concerned about the relationship between what they would have received for the same care when those payments are provided directly versus what they wind up with through the managed-care system.

How would the administration view providing Medicare, direct medical education, as well as disproportionate share payments directly to teaching hospitals which provide care to Medicare beneficiaries who are part of a managed-care plan?

Mr. VLADECK. We have been looking at this issue, sir, and have given it a lot of thought. I have had many conversations with the teaching hospitals, and, to tell you the truth, we haven't yet figured out what the right thing to do is. If I could take a minute, I'll tell you what some of our thinking is.

It is clear that the way in which we calculate Medicare HMO payments includes dollars that in the fee-for-service sector go to support graduate medical education and disproportionate share. And to the extent teaching hospitals either don't get the business of the patients from the HMO's or negotiate prices with the HMO's that don't include those dollars, those subsidies go elsewhere in the system other than to the teaching hospitals. That is absolutely correct.

On the other hand, in principle, the contracts that those teaching hospitals enter into with the HMO's are private, arm's-length transactions, which, in general, we have thought we should not be interfering in at all. The more important consideration is that over time, as more and more of the population is in managed-care plans, it will become necessary for the managed-care plans themselves to

begin to address the issue of having an adequate supply of future physicians and other professionals for their plans.

So we would like to promote a process through which the managed-care plans themselves begin to assume more of the responsibility for the support of graduate medical education, as is the case in some parts of the country. We have encouraged a dialogue between the managed-care industry and the teaching hospitals.

We think it is in the long-term interest of both the HMO's and the hospitals to support teaching, research, and disproportionate share activities and we would prefer to encourage the parties to figure out some voluntary approach to the problem. To the extent that doesn't begin to happen, then we would have to look at a legislative solution, but we are not there yet.

Mr. GREENWOOD. What is your sense of the time frame to come to closure on this?

Mr. VLADECK. Well, frankly, while the concerns of the academic centers are very real and legitimate, they are still at very early stages in most communities. At the moment, we estimate the total number of dollars that are not being paid to teaching hospitals because patients are in HMO's rather than in fee-for-service to be under $500 million this year.

But as Medicare HMO's grow, it becomes more of an issue. If we think in terms of legislative cycles, this is probably more appropriate as a 1996 issue, in the second session of this Congress.

Mr. GREENWOOD. Thank you.

Seeing that we have no other members present, I would like to thank you for your testimony and excuse the witness.

We are going to adjourn now until 1:15 p.m. The hearing stands adjourned.

[Whereupon, at 12 o'clock, the subcommittee recessed, to reconvene at 1:15 p.m., the same day.]

Mr. GREENWOOD. This hearing of the Health and Environment Subcommittee will reconvene.

Mr. BURR. Mr. Chairman, may I ask unanimous consent in lieu of our ability to ask questions in the last panel to make some additional statements into the record?

Mr. GREENWOOD. Without objection.

I would like to call forward our third panel: the Honorable William Gradison, Mr. Gordon Sprenger and Ms. Karen Ignagni. Thank you.

And perhaps we will begin with Mr. Gradison.

STATEMENTS OF WILLIAM GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA; GORDON SPRENGER, EXECUTIVE OFFICER, ALLINA HEALTH SYSTEM; AND KAREN IGNAGNI, PRESIDENT, GROUP HEALTH ASSOCIATION OF AMERICA

Mr. GRADISON. Thank you, Mr. Chairman.

Mr. Chairman, members of the subcommittee, Medicare is a highly valuable, immensely popular program which has served the medical needs of the elderly and the disabled quite well over almost three decades. But the program isn't perfect, and reexamining Medicare broadly, as you are beginning to do, is indeed timely.

In many respects, Medicare is a state-of-the-art 1965 health insurance program. Both the benefit package and the delivery systems are pretty much the same as they were at the outset. While important and useful changes have been made in the program—DRG's, RBRVS or the HMO/CMP options, Medicare Select options—these amount to tinkering around the edges.

In my judgment, were the Congress to design a program today to serve the elderly and the disabled, it would look very different from Medicare as we know it in at least two regards: first, the benefit package and, second, the delivery system. It is inconceivable to me, for example, that Medicare, if it started anew, would exclude outpatient prescription drugs. I am also skeptical that a one-size-fit-s-all benefit package would be adopted. It is also doubtful to me that the program would be overwhelmingly fee-for-service if started today.

Having grappled with Medicare policy for years, I know how hard it is to make minor—to say nothing of major—changes in Medicare. I believe we can be helpful in your deliberations since HIAA member companies, whom I represent, are involved in all aspects of Medicare—as carriers and intermediaries for fee-for-service carriers of the program; as providers of the supplemental insurance that beneficiaries purchase to augment their Medicare fee-for-service benefits; and as providers of the Medicare HMO/CMP and Medicare Select managed care options that are available to beneficiaries in many parts of the country.

Frankly, we have not focused internally on what specific changes to recommend were Medicare as a whole to be restructured. We do know that achieving Medicare program cost reductions would merely shift the cost to the private sector, making health insurance more costly for the nonMedicare population and making care for the elderly population less available. Increasing this cost shift from the public to the private sector is, in essence, a tax on the private sector.

Quite apart from whatever major restructuring you may decide upon, we recommend that Medicare's managed care program be expanded now. HCFA is examining allowing PPO options to be offered to Medicare beneficiaries. More than 76 million Americans receive health coverage through PPO's. It is time that seniors have the same choice.

Cost reimbursement rather than risk contracts may expand access to managed care in some geographic areas. Speeding up HCFA approval of managed care contracts would also help. This process can be streamlined particularly for managed care plans which have already been approved as risk contractors and are seeking to expand or enter new geographic markets.

Beneficiary satisfaction levels with current Medicare managed care plans are high. Medicare managed care choices offer lower costs, expanded benefits, less paperwork, coordination of care and case management.

Obviously, for today's elderly population, a network-based delivery system is largely foreign to them. They should not be forced to participate but rather be given incentives.

Many private-sector plans offer managed care to their current employees. We would suggest the development of a mechanism to

permit a retired employee to remain in the employer's managed care plan as a Medicare option. For those retirees who choose to remain in the employer's plan, the ability to assure seamless continuation of their coverage would greatly enhance beneficiary satisfaction.

The Medicare Select program is one example of a managed care initiative that is working now to give seniors the option of saving money by moving into a managed preferred provider setting. We strongly support expansion of this program to seniors in all 50 States and making the program permanent.

Congress must move quickly on Medicare Select since the extension signed into law at the end of 103d Congress expires in June.

In closing, Mr. Chairman, the HIAA stands ready to work with the Congress on Medicare restructuring options and health care reform in general. Of course, we will need to see the details of various proposals before we will be able to comment in detail. It is healthy that discussion is taking place about this new paradigm for managed care plans. Well-managed networked-based care is a partnership of providers, payers and beneficiaries. All of these parties should participate in discussions regarding the restructuring of this important government program.

Many thanks for this opportunity appear here today, Mr. Chairman.

[The prepared statement of Bill Gradison follows:]

PREPARED STATEMENT OF BILL GRADISON, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA

I am Bill Gradison, President of the Health Insurance Association of America (HIAA). The HIAA represents 230 of the Nation's commercial health insurers, covering 55 million Americans. I am delighted to have the opportunity to participate in this important hearing on the future of managed care in the Medicare program.

HIAA member companies are involved in all aspects of Medicare: as carriers and intermediaries for the fee-for-service segment of the program; as providers of the supplemental insurance that beneficiaries purchase to augment their Medicare fee-for-service benefits; and as providers of the Medicare HMO, CMP and Medicare Select managed care options that are available to beneficiaries in many parts of the country.

Among the HIAA member companies involved in Medicare managed care are Bankers Life and Casualty, FHP, Healthsource, Humana, Intergroup, New York Life, Principal Health Care, Sierra Health and Life, and Wellpoint. Outside of Medicare, our member companies have enrolled over 25 million of the 100 million Americans estimated to be in private managed care plans. Their record in Medicare is similar. They have enrolled nearly 700,000 of the 3 million seniors covered by plans under contract with Medicare.

Looking into the future, Medicare managed care plans will enjoy large gains in enrollment as the current working population covered by managed care will choose to continue to have their health care coverage through managed care plans when they retire. But, unless the overall structure of Medicare is radically altered, there will always be a substantial Medicare fee-for-service population that will want to purchase traditional Medicare supplemental insurance to augment their Medicare benefits.

Over the past decade, Medicare's managed care options have become an increasingly important part of the program—and deservedly so. Managed care options offer seniors the benefit of coordinated health care, as well as coverage, such as prescription drugs coverage, not provided by Medicare, at a very competitive cost. Yet, the growth of Medicare managed care has been considerably slower than the rapid expansion of managed care enrollment in the under age 65 population.

The Medicare HMO program is available to 74 percent of Medicare beneficiaries and currently covers just over 3 million beneficiaries. Compared to the rapid expansion of managed care in the private sector, particularly, among employee group

health benefit plans, Medicare managed care, despite recent favorable enrollment trends, has not kept pace. We believe that there are several reasons for this.

These reasons have to do with basic differences between Medicare and the employee health benefits market, incentives for beneficiaries to participate in managed care plans, incentives for additional health plans to participate in this market, the lack of an adequate spectrum of Medicare managed care options for beneficiaries and the lack of adequate efforts to inform them about the existing ones, current Medicare beneficiaries' lack of familiarity with network-based delivery systems and, finally, the potential for government to overregulate, rather than to rely upon the private marketplace to produce the desired results. In addition, we should look more broadly at how the Congress can establish new managed care options for beneficiaries.

The Health Care Financing Administration (HCFA) is seeking to expand the role of Medicare managed care to help contain its burgeoning program costs. For a variety of reasons, HCFA has come to prefer contracting with managed care plans on a risk rather than cost reimbursement basis. Yet, after 10 years of risk contracting with HMO's and Competitive Medical Plans (CMP's), there is still a lively debate over whether the premium that Medicare pays to risk plans is adequate compensation for the risk to be assumed.

Those who believe that risk premiums under the current formula are inadequate argue that many new enrollees in Medicare managed care plans join because they have been unable to afford Medicare's cost sharing requirements or supplemental insurance. They enroll in a Medicare risk HMO or CMP because the cost sharing requirements are minimal, and, once enrolled, their previously unmet health care needs far exceed the care utilized by an average Medicare beneficiary. Low income beneficiaries, they say, are four times more likely than average beneficiaries to enroll in a Medicare HMO or CMP. These examples may explain why, historically, a substantial number of risk plans have dropped out of the program or have converted to cost-reimbursement contracts.

Many health policy experts believe that if managed care can capture a substantial portion of the health care market in a given area, its ability to provide benefits in a cost effective high quality manner and at a lower premium exerts a competitive cost containment effect on the entire health care marketplace. Medicare risk contractors complain, however, that where they have achieved a sizable share of the Medicare beneficiary market—thus driving down the average cost per Medicare beneficiary—the AAPCC formula "rewards" them by reducing the premium paid by the government to 95 percent of this lower cost average. Removing this fundamental disincentive on the part of health plans and providers to become more efficient (while lowering cost and insuring quality), will encourage greater participation by health care plans and provide beneficiaries with new or expanded access to the benefits of receiving their Medicare benefits through a managed care plan.

There are other barriers to increasing the enrollment in Medicare managed care programs that could be addressed such as education and publicity for beneficiaries as to their managed care options and expedited approvals for risk contractors.

It may also be appropriate for the government to ease, perhaps temporarily, some of the regulatory requirements for managed care contractors, in the interest of opening new managed care markets. We believe that this can be done, carefully and selectively, without sacrificing the critical elements of consumer protection and quality assurance. However, all plans, in all markets, should have to be certified under the Federal HMO law, or state-licensed, in order to assure appropriate oversight of their solvency, fiduciary responsibilities and the quality of care they provide their customers.

Our member companies report that it takes up to a year and a half to meet all of HCFA's information requirements and receive approval of a risk contract application. They believe that this process could be streamlined to its essential components and appreciably shortened in terms of cost and time.

HCFA should be authorized to waive aspects of the application process that are redundant for managed care plans which are already approved as risk contractors and are seeking to expand or enter into new geographic markets.

Congress and the administration might also consider reducing the redundancies that exist with respect to the oversight of quality of care. Managed care plans are reviewed by the Medicare program, state regulators, and may also be reviewed by private accrediting organizations. It would produce cost and time savings, while at the same time insuring beneficiary protection and health plan quality, for appropriate private managed care accreditation to be accepted by the Medicare program.

Anti-managed care laws, such as any-willing-provider and similar statutes, whether state or Federal, can only undercut Medicare's interest in promoting managed care among its beneficiaries. Requiring a network to contract with all providers

or over regulating the selectivity of networks increases the cost of delivering care and may negatively impact quality. Federally qualified HMO's are exempt from such statutory obstacles that have been enacted in a few States. Congress should extend this same preemption to Competitive Medical Plans (CMP's), Medicare Select, and any yet-to-be developed managed care options for Medicare beneficiaries.

At present, Medicare beneficiaries can drop out of managed care plans almost at will. This makes beneficiary satisfaction a critical ingredient that must be addressed in any strategy for expanding Medicare managed care. The GAO advises that two thirds of those who leave a Medicare HMO or CMP do so to join another one with more attractive benefits.

There is a reluctance of many of today's beneficiaries to enroll in managed care options. Managed care networks are foreign territory to them. Even the availability of extra benefits such as coverage for prescription drugs and elimination of the need to pay premiums for Medicare supplemental insurance, are insufficient incentive, in and of themselves, for some beneficiaries to choose to receive their Medicare benefits through a managed care option.

Except for emergency or out-of-area care, Medicare HMO and CMP's require beneficiaries to get their care within the contractors' delivery systems. In order to broaden the appeal of managed care, Medicare needs to create additional options, emulating private managed care. Many private plans provide consumers managed care coverage while allowing them to occasionally use out-of-network providers if they are willing to accept a reduced level of benefits, such as higher copayments, when they do so.

Another option that would dramatically increase Medicare Managed care enrollment could be based on the model of employer-employee managed care health benefit plans. Many of these plans offer their enrollees a variety of managed care options. We recommend the development of a Medicare option that would permit a retired employee to remain, by choice, in the employer's managed care plan. The retiree could still choose to enroll in the fee-for-service segment of Medicare, or choose an available Medicare managed care option. For those retirees who chose to remain in the employer's managed care plan, the ability to assure "seamless" continuation of their coverage would greatly enhance beneficiary satisfaction and promote administrative savings for all parties. There have been a couple of successful demonstrations of this concept. What is needed now is a focused effort aimed at enabling members of managed care plans to remain with their current managed care plan (or another of their choosing), as they become eligible for Medicare benefits.

However, at present there are several impediments preventing the offering of a full spectrum of plans to Medicare-eligible beneficiaries. The current Medicare managed care options are limited exceptions to the general Medicare law which prevents the Medicare program from limiting the providers from which a Medicare beneficiary can receive services. Congress should consider broadening Medicare managed care to permit more health care options to be offered to Medicare beneficiaries. Such options should include preferred provider organizations (PPO's) and Point of Service plans (POS). HIAA is pleased that HCFA is examining allowing PPO options to be offered to Medicare beneficiaries. More than 50 million Americans receive health benefit coverage through PPO's. It is time that seniors have the same choices as those who obtain health care coverage through their work-place.

Another barrier facing managed care organizations vis a vis the Medicare program is the lack of appropriate protection ("safe harbor") from Federal anti-kickback laws which apply to the Medicare and Medicaid programs. The Medicare/Medicaid anti-kickback laws frustrate the offering to Medicare beneficiaries of many innovative managed care arrangements that are common in the private sector. Specifically, section 1128(B)(b) prohibits offering or paying renumeration as an inducement for making a referral for: (1) the furnishing or arranging for items and services; or (2) arranging for goods, facilities, services, or items.

While the concern about kickbacks is a legitimate one, there needs to be greater accommodation of worthwhile managed care practices common in the private marketplace that are effective and serve the interests of beneficiaries and the Medicare (and Medicaid) programs as payors. Appropriate expansion of the regulatory safe harbors is recommended to serve the interest of expanding Medicare managed care options.

In 1990, Congress took a major step toward broadening the spectrum of Medicare's managed care options by authorizing a 15 State demonstration of a preferred provider organization (PPO) type of Medicare supplemental coverage called Medicare Select. This option does allow beneficiaries to use out-of-network providers at the cost of receiving reduced coverage for their services. While the demonstration got off to a slow start, it is now growing rapidly and is attractive to beneficiaries.

As discussed below, we urge Congress to move quickly to make Medicare Select a permanent, national Medicare option.

The Medicare Select program is one managed care initiative that is working now to give seniors the option of saving money on their Medicare supplemental insurance policies by joining a preferred provider network. Medicare Select expands choice for consumers by making Medicare supplemental insurance coverage more affordable, without sacrificing important consumer protections. The program was designed to bring seniors' choices up-to-date with PPO products widely available to the under 65 population.

In the 15 Medicare Select States, over 440,000 seniors are paying 10 percent to 37 percent less in premium dollars for Medicare Select policies when compared to certain traditional fee-for-service supplemental policies. This translates into savings of as much as $25 per month or $300 per year for individuals, many living on fixed incomes, thus freeing up approximately $132 million dollars in purchasing and savings power for other use by those seniors who are now participating in the program.

For the consumer, Medicare Select offers flexibility. Under the Medicare Select program, if care is provided by the network's hospitals or physicians, the full supplemental insurance benefit is paid. If services or care is provided outside the network, the beneficiary is still entitled to receive the full Medicare reimbursement, and a reduced supplemental benefit is paid.

The Medicare Select program is one example of a benefit package that offers seniors the means to protect themselves from health care costs. In addition to monthly premium savings, there are out-of-pocket savings for seniors as well. By seeking care from Medicare Select networks, subscribers are protected from physician balance billing.

And, like all Medicare supplemental insurance policies, Medicare Select products are among the most tightly regulated products today. Current rules safeguard consumers by requiring networks to offer sufficient access, ongoing quality assurance programs, and full disclosure of network requirements. Medicare Select products must comply with all Federal regulations imposed by section 1882 of the Social Security Act, which establishes mandatory Federal standards for all Medicare-Supplemental Insurance coverage. Specifically, section 1882:

—regulates the marketing of supplemental insurance policies;

—establishes minimum loss-ratio standards;

—creates premium refund provisions in the event that minimum loss-ratio are not met; and

—limits waiting periods and pre-existing conditions exclusions.

In addition, States, through the National Association of Insurance Commissioners (NAIC), have established model legislation to protect consumers. In order to sell Medicare Select policies, insurers must file a plan of operation with the Insurance Commissioner demonstrating that:

—the network offers sufficient access to care;

—the network has an ongoing quality assurance program;

—the insurer must provide all network restrictions, including any restrictions on emergency coverage, or out-of-area coverage; and

—the insurer must provide a cost comparison of the Medicare Select product and all other Medicare-Supplemental insurance policies that the insurer sells.

Finally, Medicare Select plans that offer a fee-for-service product must allow consumers to convert to that product at any time.

Consumer satisfaction is probably the best recommendation for expanding Medicare Select to all 50 States and making this demonstration program permanent. The August 1994 edition of *Consumer Reports* rated the top Medicare supplemental insurance products nationwide, and of the top 15 rated products, 8 were Medicare Select.

The National Governors Association and the National Conference on State Legislatures have endorsed the expansion of the Medicare Select insurance coverage for seniors. The NAIC reports strong consumer satisfaction among Select policyholders, and has endorsed extension and expansion of Medicare Select to all 50 States. In fact, the NAIC has noted that in 10 Medicare Select States—Arizona, California, Florida, Illinois, Indiana, Kentucky, Missouri, North Dakota, Texas, and Wisconsin—few complaints have been reported on Medicare Select polices.

In California, where managed care networks are well developed, one HIAA member company reports that its Medicare Select program has gained 24,000 new members in the last 12 months, and it now serves over 90,000 members. In that one network, consumers have access to:

—nearly 40,000 physicians (half of which are specialists) with no balanced billing to beneficiaries;

—carefully selected providers that meet specific quality and credentialing standards;
—physician management of episode of care, including appropriate utilization and specialty referral;
—formal administrative, clinical, and peer review of the quality and appropriateness of care;
—enhanced benefits that include outpatient prescription drugs, and a range of home health, home support, and custodial services; and
—fraud and abuse detection and profiling.

As these hearings indicate, there is intense interest in private sector innovations with potential to improve the Medicare program. Medicare Select is one example of such innovation.

HIAA encourages the Congress to act quickly to extend Medicare Select. Without Congressional authorization, the Medicare Select program will be expired on June 30, 1995. Unless Congress acts by April 1, nearly one half million beneficiaries will be notified that their supplemental insurance network will no longer be able to take on new members. This will only create confusion and uncertainty. Seniors in Medicare Select States will not have the choice of using a preferred provider option for their Medicare supplemental insurance benefits. That would be an unsatisfactory answer for the public and for seniors who have challenged the Congress to make government not only smaller, and more efficient, but also more responsive to their needs.

Medicare Select is one important example of an approach to managed care that is working now to protect seniors from the high cost of medical-expenses, while preserving quality and without shifting costs to the Federal Government.

In closing, the HIAA stands ready to work with the Congress on improving the Medicare risk program, on expanding and making permanent the Medicare Select program, on general restructuring of Medicare managed care options and on health reform in general. As the details of various proposals become known, we will be glad to provide you with detailed comments and recommendations.

Thank you for the opportunity to participate today.

Mr. GREENWOOD. Thank you, Bill, for your testimony.

And we will move next to Mr. Sprenger.

STATEMENT OF GORDON SPRENGER

Mr. SPRENGER. Thank you, Mr. Chairman and members of the subcommittee.

I am the Executive Officer of Allina Health System, which is an integrated health care system composed of hospitals, nursing homes, clinics and a health maintenance organization named Medica in Minneapolis, Minnesota.

In the Minnesota marketplace, almost 200,000 Medicare beneficiaries are covered under some form of Medicare managed care program. Approximately 65,000 of those beneficiaries are served through a Medicare Select supplement product. This product option has been extremely popular amongst the beneficiaries, providers and health plans in the Minnesota market. Medica has recently developed a new Medicare Select program to further supplement the Medica options that it already provides to individuals receiving Medicare.

I am here this afternoon to speak to you about the value of the Medicare Select program in the Minnesota marketplace. This program not only provides an additional, low-cost Medicare supplement option for Medicare beneficiaries but also has been a valuable tool for Medica and other health plans to introduce and expand managed care in the rural areas of our State.

I have eight reasons that I would like to give to you, Mr. Chairman and members of the committee, as to why I believe and the organization believes that you should enact the legislation required—and hopefully by April—so that we can give a feeling of se-

curity to these seniors who are out there and are now feeling that they are being jockeyed around not knowing whether this program will be there or not.

The eight reasons are:

First, Medicare Select does offer significant cost savings to Medicare beneficiaries. In our own marketplace, the policies offer savings of approximately 10 percent over traditional indemnity supplemental programs. On a nationwide basis, the savings can be as high as 30 percent. Medicare Select does provide Medicare beneficiaries who are on fixed incomes with some peace of mind that they will not have unexpected out-of-pocket costs for significantly lower monthly premiums.

The second reason, Medicare Select does provide flexibility to Medicare beneficiaries. Unlike Medicare risk programs, Medicare Select members may opt to use non-network providers. They don't have to just stay in that network if they choose not to, yet they retain the basic Medicare coverage. If they seek services within the provider network, however, they will receive full Medicare and supplemental coverage.

Three, Medicare Select offers Medicare beneficiaries consumer protections—and we have heard some of that this morning in some of the testimony and the concern about this—which are not available to them under Medicare fee-for-service or traditional indemnity supplements.

Medicare Select is the only policy that incorporates consumer protections such as provider credentialing, ongoing quality assurance, full disclosure of network requirements and access to network beneficiaries. In Minnesota, the question came up in terms of what is access. We have a requirement in our State it must be 30 minutes or 30 miles in order to have access for networks.

Fourth, Medicare Select policies provide additional benefits to the beneficiaries beyond what they would otherwise get. Medicare Select policies generally include coverage for preventive care, prescription drugs and other nonMedicare covered services.

Five, Medicare Select provides simplified claims processing and payment. Medicare Select policies generally result in a paperless claims process for members and a more timely process, I might add, for the providers.

Sixth, Medicare Select policies have high consumer satisfaction. In August 1994, Consumer Reports rated the top Medicare supplemental insurers nationwide. Of the top 15 rated products, 8 were Medicare Select products.

Seven, Medicare Select helps introduce managed care to Medicare beneficiaries. Medicare Select is an excellent early entry as a tool for introducing managed care to senior citizens because it introduces the concept of provider networks and financial incentives for using the network and for seeking appropriate care but still there is that option, you can opt out of the network if you choose to.

And, last, we think Medicare Select, at least from our experience, is providing our health plan with the vehicle to expand managed care into the rural areas.

Current Medicare contractual options offered by HCFA prevent managed care plans from successfully moving managed care into

rural areas. The reimbursement is not sufficient to support the risk arrangements with HCFA, and special enrollment proportion rules prevent HCFA cost arrangements. As a result, Medicare Select is an ideal vehicle for expanding to and introducing managed care principles into new regions.

I appreciate very much the opportunity of being here today and to share our thoughts about Medicare Select. Obviously, we love the program and think that it should be made a permanent part of the options that are made available to senior citizens in this country. Thank you very much.

[The prepared statement of Gordon Sprenger follows:]

PREPARED STATEMENT OF GORDON SPRENGER, EXECUTIVE OFFICER, ALLINA HEALTH SYSTEM

My name is Gordon Sprenger, I am the Executive Officer of Allina Health System, which is an integrated health care system composed of hospitals, nursing homes, clinics, and a health maintenance organization named Medica. Medica is a non-profit health plan headquartered in Minnetonka, Minnesota. It currently serves over 675,000 HMO members. Among its membership, Medica serves 80,000 Medicare members under TEFRA risk, cost, or HCPP arrangements. Medica has been contracting with HCFA to serve Medicare beneficiaries for nearly 15 years.

In the Minnesota marketplace, almost 200,000 Medicare beneficiaries are covered under some form of Medicare managed care program. Approximately 65,000 of these beneficiaries are served through a Medicare Select supplemental product. This product option has been extremely popular among beneficiaries, providers and health plans in the Minnesota market. Medica has recently developed a new Medicare Select program to further supplement the Medicare options it already provides to individuals receiving Medicare.

I am here this morning to speak to you about the value of the Medicare Select program in the Minnesota marketplace. This program not only provides an additional, lower-cost Medicare supplement option for Medicare beneficiaries, but has also been a valuable tool for Medica and other health plans to introduce and expand Medicare managed care in rural areas of our State.

Medicare supplemental insurance is a health care coverage option for Medicare beneficiaries that supplements, but does not duplicate Medicare coverage. Thus, the policy may cover hospital deductibles, coinsurance, preventive services, dental services, and prescription drugs, which are not covered by Medicare. A pure Medicare supplemental product is generally offered by indemnity insurers and does not restrict a beneficiary's choice of provider. A beneficiary may obtain care from any provider and receive both Medicare and supplemental coverage.

In 15 States, Congress has authorized indemnity insurers, health maintenance organizations, and health plans to offer Medicare supplemental coverage through a selected network of providers. (Section 1882 of the Social Security Act). This special supplemental program is entitled Medicare Select.

If a beneficiary purchases a Medicare Select policy from a health plan and then receives health care services from the health plan's network providers, the beneficiary will receive full coverage for both Medicare and supplemental services. If a beneficiary seeks services outside the health plan's provider network, without prior authorization or in the absence of an emergency, the beneficiary will still be entitled to Medicare coverage, but will not be entitled to supplemental coverage, such as coinsurance, deductibles, and other additional non-Medicare covered services.

The intent and value underlying the Medicare Select program was to offer a Medicare supplemental product using principles of managed care to provide Medicare beneficiaries with an affordable supplemental Medicare option. The Medicare Select program was originally authorized in 1990 and implemented in 1992. The program is scheduled to sunset June 30, 1995. Legislation has been proposed to continue the program permanently and extend it to all 50 States. (H.R. 483 (Johnson, N.); S. 198 (Chafee)).

Medica and other health plans in the Minnesota market seek your support in continuing the Medicare Select Program as originally authorized under section 1882 of the Social Security Act. Nationwide, over 400,000 Medicare beneficiaries receive coverage under Medicare Select polices. 65,000 of these beneficiaries are Minnesota residents. An additional 120,000 Minnesota Medicare beneficiaries receive coverage under risk, cost, and health care prepayment arrangements with the Health Care

Financing Administration, pursuant to sections 1876 and 1833 of the Social Security Act.

As organizations that have successfully served and are committed to continuing serving Medicare beneficiaries, we believe it is imperative that the Medicare Select program be made permanent and extended to all 50 States. This position is based on the benefits of the program to consumers and the health care system, which are discussed below.

—Medicare Select offers significant savings to Medicare beneficiaries. In Minnesota, Medicare Select policies offer approximately 10 percent savings over traditional, indemnity supplements. On a national basis, savings can as high as 30 percent. This could result in a savings of between $10 to $30 a month, or $120 to $260 a year. Thus, Medicare Select has the ability of assuring Medicare beneficiaries, who are on fixed incomes, the peace of mind that they will not have unexpected out-of-pocket costs for significantly lower monthly premiums.

—Medicare Select provides flexibility to Medicare beneficiaries. Medicare Select offers flexibility to Medicare beneficiaries. If a Medicare Select member uses the health plan's provider network, the member will receive full coverage of Medicare and supplemental services available under the plan. If the member instead chooses to seek services outside the network, the member is still entitled to receive coverage under Medicare. This contrasts with other options available to Medicare beneficiaries under Medicare risk programs, where if a plan member seeks care outside the provider network, the member will not receive *any* coverage unless the services were prior authorized or were obtained under emergency conditions.

—Medicare Select offers Medicare beneficiaries consumer protections that are not available under Medicare fee-for-service or traditional indemnity supplements. Medicare Select is the only supplement policy that incorporates consumer protections such as provider credentialing, ongoing quality assurance, full disclosure of network requirements and sufficient network access. Restrictions are also placed on how Medicare Select products may be sold, commissions paid, and prior coverage replaced. All of these protections combine to offer beneficiaries the freedom of a Medicare "point-of-service" option, with the accountability of a managed care health plan. For example, Medica serves its Medicare Select members through the same provider network that serves its other HMO enrollment. Participating providers are credentialed and must meet on-going quality, utilization and performance standards. When serving patients, providers do not distinguish one type of coverage or member from another and, therefore, efficiency, quality and service principles integral to managed care are applied to all members, including Medicare Select members.

—Medicare Select policies provide additional benefits to beneficiaries. Most Medicare supplemental and Medicare fee-for-service coverage does not provide coverage for preventive care, prescription drugs, preventive dental services, and other non-Medicare covered services. Many Medicare Select products build these benefits into the Medicare Select package. Thus, for less cost, Medicare Select beneficiaries have access to a more comprehensive benefit package that focuses on preventive and primary care.

—Medica Select policies provide simplified claims processing and payment. Most health plans can design their Medicare Select policies so that they receive electronic communications from Medicare, which indicates Medicare's payment and any outstanding claims owed by the health plan. This results in a paperless system for the Medicare beneficiary and more timely payments for providers. Consequently, beneficiaries and providers alike are happy with this program.

—Medicare Select policies have high consumer satisfaction. In August 1994, *Consumer Reports* rated the top Medicare supplement insurers nationwide. Of the top 15 rated products, eight were Medicare Select products.

—Medicare Select helps introduce managed care to Medicare beneficiaries. Medicare Select is an excellent tool for introducing managed care to individuals who might otherwise be adverse to it. Medicare Select introduces the concept of provider networks and financial incentives for using network care and seeking appropriate care. These elements are combined with offering the "peace of mind" that a beneficiary can still seek care out of network, but at a higher cost. Thus, Medicare Select provides a transitional product for individuals who might not otherwise be comfortable with a managed care program.

—Medicare Select provides health plans with a vehicle to expand managed care into rural areas. Many States, including Minnesota, have successful managed care programs, but they are focused largely in metropolitan, urban settings. To further managed care efficiencies, quality and outcomes, there has been a strong effort to introduce Medicare managed care into more rural regions of the State.

Current Medicare contractual options offered by HCFA prevent managed care plans from successfully moving Medicare managed care into rural regions. Reimbursement is not sufficient to support risk arrangements with HCFA, and special enrollment proportion rules prevent HCFA cost arrangements (i.e., the 50/50 rule). As a result, Medicare Select is an ideal vehicle for expanding to and introducing managed care principles into new regions.

Through Medicare Select, beneficiaries are able to purchase a less expensive product, are introduced to a provider network delivery system with managed care controls and protocols, have an entity they can contact that is accountable to them for arranging care and addressing issues, and have peace of mind to go out of the network at some additional cost.

Currently, over 400,000 Medicare beneficiaries are enrolled in the 15-State Medicare Select program. Almost 65,000 of these beneficiaries are Minnesota residents. The impact of terminating the Medicare Select program will be significant. A few of the consequences are outlined below:

—Member notification. If Medicare Select is not continued, health plans will have to begin notifying their Medicare Select beneficiaries that the program has ended and they will either need to convert to another Medicare product or remain in the program with the likelihood of higher premiums in the future. Under Minnesota law, health plans are required to provide guaranteed renewability to Medicare Select beneficiaries. Thus, beneficiaries cannot be required to move to another Medicare coverage option but may choose to remain in the Medicare Select program, which would be closed to new enrollment.

—Premiums will increase for existing Medicare Select enrollees. While current beneficiaries must be allowed to remain in the Medicare Select program, health plans will not be able to enroll new Medicare beneficiaries after the program expires. Without new enrollees, current membership will continue to age and will naturally need additional services as they become older and possibly sicker. This is commonly referred to as the "death spiral." As utilization increases, premium costs must also increase to continue to support the product and meet the aging members' needs. This will result in higher cost to members.

—New Medicare beneficiaries entering into the supplemental market will no longer have lower Medicare supplemental premium options. As new Medicare beneficiaries enter the Medicare Supplemental market, they will no longer have a Medicare supplemental product that is less expensive as a result of managed care. Most Medicare beneficiaries will have the limited options of remaining in Medicare fee-for-service, thereby exposing them to significant out-of-pocket costs, choosing a risk health plan that locks them into a provider network with no flexibility to seek out-of-network care, or purchase a pure indemnity Medicare supplement, which can be between 10 to 30 percent more expensive than Medicare Select supplements.

—An important vehicle for extending managed care into rural areas will be terminated. Without Medicare Select, health plans in States such as Minnesota, will lose their flexibility to expand into rural areas of the State, introduce managed care, extend its success, and provide Medicare beneficiaries with a lower cost Medicare supplement. If health plans are limited to only offering risk or cost Medicare plans to beneficiaries, they will not be able to support these products in areas of the State with less developed managed care and often lower reimbursement. Without Medicare managed care in rural areas, managed care will not be able to expand beyond metropolitan settings. Thus, ending Medicare Select could ultimately prevent the future success of managed care.

In light of the above, on behalf of Medica and other Minnesota health plans, I respectfully request your support of extending the Medicare Select program to all 50 States and making the program permanent. This action must be completed by April 1, 1995, to ensure continued existence of the Medicare Select program without any disruption to current Medicare beneficiaries who have Medicare Select coverage. Supporting this legislation will ensure an affordable Medicare coverage supplemental product, offering value-added benefits within a managed care framework. Individuals on fixed incomes and entitled to Medicare, should have options like this available to them as they did before they became eligible for Medicare.

Thank you for the opportunity to participate today. I appreciate your time and consideration of this important issue.

LEGISLATION TO EXTEND MEDICARE SELECT SHOULD BE ENACTED BY APRIL 1, 1995, TO PRESERVE AN IMPORTANT MEDICARE SUPPLEMENT PROGRAM

Medicare Select programs offer significant benefits to Medicare beneficiaries.

—Over 400,000 Medicare beneficiaries are enrolled in Medicare Select programs in 15 States. Almost 65,000 of these enrollees are Minnesotans.

—Medicare Select offers significant savings to Medicare beneficiaries. In Minnesota these savings average approximately 10 percent over traditional, indemnity supplements. On a nation-wide basis, the savings can be as high as 30 percent. Thus, Medicare Select provides Medicare beneficiaries, who are on fixed incomes, with peace of mind that they will not have unexpected out-of-pocket costs for significantly lower monthly premiums.

—Medicare Select provides flexibility to Medicare beneficiaries. Unlike Medicare risk programs, Medicare Select members may opt to use non-network providers, yet still retain Medicare coverage. If they seek services within the provider network, however, they will receive full Medicare and supplemental coverage.

—Medicare Select offers Medicare beneficiaries consumer protections that are not available to them under Medicare fee-for-service or traditional indemnity supplements. Medicare Select is the only supplement policy that incorporates consumer protections such as provider credentialing, ongoing quality assurance, full disclosure of network requirements, and sufficient network access to Medicare beneficiaries.

—Medicare Select policies provide additional benefits to beneficiaries. Unlike traditional indemnity supplements or Medicare fee-for-service, Medicare Select policies generally include coverage for preventive care, prescription drugs, and other non-Medicare covered services.

—Medicare Select polices provide simplified claims processing and payment. Medicare Select policies generally result in a paperless claims process for members and a more timely payment process for providers.

—Medicare Select policies have high consumer satisfaction. In August 1994, *Consumer Reports* rated the top Medicare supplement insurers nationwide. Of the top 15 rated products, eight were Medicare Select products.

Medicare Select offers system reform by expanding managed care.

—Medicare Select helps introduce managed care to Medicare beneficiaries. Medicare Select is an excellent tool for introducing managed care, because it introduces the concept of provider networks and financial incentives for using network care and seeking appropriate care.

—Medicare Select provides health plans with a vehicle to expand managed care into rural areas. Current Medicare contractual options offered by HCFA prevent managed care plans from successfully moving Medicare managed care into rural regions. Reimbursement is not sufficient to support risk arrangements with HCFA, and special enrollment proportion rules prevent HCFA cost arrangements (50/50 rule.) As a result, Medicare Select is an ideal vehicle for expanding to and introducing managed care principles into new regions. Through Medicare Select, beneficiaries are able to purchase a less expensive product, are introduced to a provider network delivery system with managed care controls, and have available to them an accountable entity to address their needs. The ultimate success of managed care is dependent upon the ability of managed care to expand to rural regions.

Mr. GREENWOOD. I thank the gentleman for his excellent testimony.

We are now going to recognize Ms. Ignagni for her testimony. Just to give you a heads up, there is this vote and another vote. What we would like to do is take your testimony, recess for 10 minutes, make these votes, and then reconvene. You may proceed.

STATEMENT OF KAREN IGNAGNI

Ms. IGNAGNI. Thank you, Mr. Chairman.

I am Karen Ignagni, the President of the Group Health Association of America. Our 375 member plans are serving approximately 80 percent of the 50 million people in HMO's today.

With your permission, I would like to request that my testimony be submitted into the record; and I would like to take this opportunity to perhaps comment on some of the questions that were fielded earlier today in an effort to try to be helpful and move the discussion along.

The first item is the issue and the matter of who is in managed care under Medicare. I thought it might be helpful to draw the committee's attention to the fact that now HMO's are serving approximately 3.1 million people through risk cost contracts in addi-

tion to the 400,000 in Medicare Select that has been the focus of much of the discussion this morning.

The second issue that I would like to address is the track record of HMO's. There was quite a lot of discussion about what managed care has meant in the Medicare area as well as for the under-65 population, and I think there are several interesting points for the committee's consideration.

The first point is I think to let the beneficiaries both under 65 as well as over 65, beneficiaries of both employer-based systems as well as public programs such as Medicare, speak for themselves. The satisfaction rates are very compelling when you look across the board at health status.

In the past, we had quite a lot of stretchy data and anecdotal information about satisfaction. Now we have included in our testimony a new study by the National Research Council which shows and displays satisfaction across the board, notwithstanding health care status where HMO's have a far better track record. And that is a matter that came up this morning, and the committee might want to take some time to study and perhaps I would be prepared to answer questions about some of the specific satisfaction rates our member plans are seeing.

Second, in terms of quality, the studies that are coming out with respect to quality indicate that HMO's have as comparable quality or better in some cases, particularly for those who are chronically ill, and would provide some information with respect to those studies also in our testimony.

Cost. There is quite a lot of discussion on the cost matter. For the under-65 population, there has been quite a lot of information in the newspapers recently about the recent Foster/Higgins study which shows the dramatic differences in rates of increase for fee-for-service versus managed care. I would also draw the committee's attention to the Peat Marwick studies that have established a longitudinal track record with respect to the cost curve being far less in managed care versus fee-for-service.

Now, for the over 65, there is quite a lot of discussion about the Mathematica report. I would like to make several observations. One is the Mathematica report is a reprise of data based on what was occurring in the HMO market in Medicare risk in the late 1980's. I will suggest that both enrollment has increased in Medicare HMO's since that time by 75 percent as have the number of plans participating in the program. So I would respectfully suggest that the situation today may be very different than the situation we saw in the late 1980's. And, indeed, we have commissioned several studies which we hope to provide to the committee in an effort to be helpful with respect to the newer data.

We have tried to provide information on the spillover effect in terms of what it means in terms of managed care being present in the local community and what has happened on the fee-for-service side, encouraging data from the Urban Institute and the Georgetown Health Policy Center, and we provide that.

Who are we serving? There was an assertion or suggestion—perhaps lack of understanding—that if HMO's are differentiating from one individual to another. Our plans take all comers, point number one.

Point number two, the law of large numbers would suggest that when we have been reaching the penetrations that we are in various markets it is virtually impossible to differentiate among those who are ill and those who are not. And the data that we have from our individual plans suggests very, very strongly not only that our plans are doing an exceedingly good job managing those who are chronically ill and providing the kinds of services that simply don't exist in the fee-for-service market, namely the coordination of care, but the satisfaction and the track records and now the study to support those contentions.

Finally, in terms of what Congress ought to do, we would suggest that you might differentiate between the short-term and long-term agenda. On the short term side, we join with my colleagues in suggesting that Congress go ahead on the Medicare Select side.

And in terms of the Medicare issue in general, the larger question of what we do, we have provided in the statement some analysis of some of our preliminary thinking; and I would be delighted to answer questions about that.

Thank you very much.

[The prepared statement of Karen Ignagni follows:]

PREPARED STATEMENT OF KAREN IGNAGNI, PRESIDENT AND CEO, GROUP HEALTH ASSOCIATION OF AMERICA, INC.

Mr. Chairman and members of the committee, I am Karen Ignagni, President of the Group Health Association of America (GHAA). GHAA is the leading national association for health maintenance organizations (HMO's). Our 375 member HMO's serve 80 percent of the 50 million Americans receiving health care from HMO's today.

GHAA and its member plans come to the committee not as theorists or academics, but as the Nation's largest body of practical, market-based experts in making HMO options available to beneficiaries and in operating successful plans. We are pleased that the committee is looking at the success of Medicare risk contracting and opportunities for expanding HMO and other managed care choices available to Medicare beneficiaries. We thank you for allowing us to testify this morning, and would like to review four issues with the committee:

—The success of the current program in which Medicare beneficiaries are offered an HMO/CMP[1] choice;

—Medicare's problems as it lags behind the rest of the health care market in its use of HMO and other managed care arrangements;

—A long-term vision for bringing the Medicare program up-to-date for beneficiaries; and

—Mechanisms to begin to move toward that vision, requiring phased transitions, and starting with some short-term changes in the existing program.

As changes are made in the Medicare program, we support reaffirmation of the fundamental goal of the program—to afford older Americans the security of access to a core set of health benefits. The program should be strengthened to guarantee the continued fulfillment of the Nation's commitment to its older citizens.

As of this January, 3.1 million Medicare beneficiaries had chosen to be served through one of the HMO contracting options offered by the Medicare program. Since 1990, the enrollment in Medicare risk plans has doubled while combined enrollment in all HMO options has grown by 70 percent. Further, there are 209 plans participating in the Medicare program, representing an increase of 48 percent over the number of plans participating 5 years ago (risk contracting plans alone have increased by 60 percent).

The Medicare HMO contracting program is a success by the most important measure we can identify—the satisfaction of the beneficiaries who have chosen this approach. During the past year, numerous groups have conducted patient satisfaction surveys, all of which show that HMO subscribers are more satisfied overall with

[1] Competitive medical plans (CMP's) are HMO's that have not chosen to become federally qualified but meet similar Federal standards. For the remainder of the testimony, we use the term "HMO" to refer to both HMO's and CMP's.

their health plan than fee-for-service subscribers. This is true for the elderly as well as Americans under the age of 65. Figure 1 is based on a national survey of over 19,000 elderly Americans conducted by the National Research Corporation based in Lincoln, Nebraska. The graphic shows that for all levels of self-designated health status, the elderly enrolled in HMO's are more satisfied with their coverage than the elderly receiving services under the traditional Medicare fee-for-service program. This graphic emphasizes that HMO's achieve higher subscriber satisfaction not just among the healthy, but also among the sick. This is one reason that HMO enrollment continues to grow—among the young and healthy, and among the older and less healthy populations.

There are many reasons for beneficiaries to be satisfied with their Medicare HMO. First, beneficiaries fill out much less paperwork. Under the fee-for-service Medicare program, beneficiaries file claims paperwork every time they receive services. In Medicare risk HMO's, the paperwork required of beneficiaries is little more than the application to join the plan.

Another benefit to seniors is coordination of care and a comprehensive care orientation. HMO's make preventive services not covered by the fee-for-service Medicare program broadly available to the beneficiaries who select them. The beneficiary's primary physician not only keeps track of all medications and tests that the beneficiary receives within an HMO, but the physician helps the beneficiary coordinate health care from specialists and hospitals. HMO's treat beneficiaries on a continuing basis, as whole persons rather than series of ailments.

In Medicare HMO's, beneficiaries have fewer and more predictable out-of-pocket costs and fewer worries about coordination of out-of-pocket and government payments. Medicare coinsurance and deductibles are translated into a monthly premium so that rather than paying 20 percent of the cost of services after the deductible is met, a beneficiary in an HMO usually pays a nominal copayment (usually $5 or $10) for doctors' services.

Finally, in addition to these benefits, Medicare HMO's offer high quality health care. A recent study by the Health Care Financing Administration showed that elderly HMO members with cancer are more likely to be diagnosed at an early stage than those in the fee-for-service sector.[2] This is due to coverage and improved access to preventive care under comprehensive HMO coverage which was also highlighted in a study by the Center for Disease Control and Prevention (CDC) and the National Center for Health Statistics.[3] The CDC study showed that women in HMO's are more likely to obtain mammograms, pap smears and clinical breast exams than those in the fee-for-service sector. Another study which supported the HMO approach to care compared the process and outcome of care for hospitalized HMO and fee-for-service patients age 65 and older with acute myocardial infarction (heart attack). This study, published in the *American Journal of Public Health,* concluded that HMO patients received better care than that received by patients in a national fee-for-service sample.[4] These are just a few of numerous studies showing that Medicare HMO's provide care of an equal or higher quality than that provided by the fee-for-service sector.[5]

While HMO's and other managed care plans have proven successful in private markets, and in meeting the needs of 3.1 million Medicare beneficiaries, Medicare lags significantly behind the private sector in making available managed care options. Twenty-two percent of individuals with health insurance in the employer-based market were enrolled in HMO's in 1993, and an additional 29 percent are enrolled in a preferred provider organization or point-of-service plan.[6] Under Medicare, approximately 9 percent of beneficiaries are enrolled in HMO's.

While some degree of caution is always appropriate in implementing changes in a program like Medicare, the gap between Medicare and the private market is now far too wide. Medicare was originally designed to provide the elderly, and later the disabled, with health coverage and access to services comparable to that of the rest

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[2] G. Riley, A. Potosky, et al., "Stage of Cancer at Diagnosis for Medicare HMO and Fee-For-Service Enrollees," 84 *Am. J. Public Health* 1598 (October 1994).

[3] *CDC/NCHS Advance Data No. 254,* August 3, 1994.

[4] D. Carlisle, A. Sui et al., "HMO vs Fee-For-Service Care of Older Persons with Acute Myocardial Infarction," 82 *Am. J. Public Health* 1626 (December 1992).

[5] *See* D. Clement, S. Retchin, R. Brown, and M. Stegall, "Access and Outcomes of Elderly Patients Enrolled in Managed Care," 271 *J. Am. Med. Assoc.* 1487 (May 18, 1994); S. Retchin, D. Clement, et al., "How the Elderly Fare in HMO's: Outcomes from the Medicare Competition Demonstrations," 27 *Health Services Res.* 651 (December 1992); J. Preston and S. Retchin, "The Management of Geriatric Hypertension in HMO's," 39 *J. Am. Geriatrics Soc.* 683 (July 1991); N. Lurie, J. Christianson, et al., "The Effects of Capitation on Health and Functional Status of the Medicaid Elderly," 120 *Annals Internal Med.* 506 (March 15, 1994).

[6] KPMG Peat Marwick/Wayne State University Survey of 1,953 Firms, 1993.

of the population. But the private health care market has changed dramatically—most notably in the increased use of HMO's and other types of managed care. Medicare has not similarly changed.

The question meriting attention by the committee is why? I would suggest two sets of answers—one short-term, one long-term.

The short-term answer is that the current Medicare risk contracting system, despite its success in some markets, has several problems.

First, the payment methodology, known as the adjusted average per capita cost (AAPCC), is flawed. Payment rates are tied to the Medicare fee-for-service costs in a given area, and do not give the Medicare program the benefits of market dynamics present in the private sector. Problems with the payment methodology have also inhibited expansion of risk contracts in some geographic areas. In addition, the payment rates are unstable from year to year, which makes planning difficult for HMO's. Further, risk adjustment factors must be improved.

Second, some HMO's that are well established in the Medicare program are unable to expand their enrollment despite interest from Medicare beneficiaries because no waiver authority exists from the requirement that no more than 50 percent of a plan's membership can be comprised of Medicare and Medicaid beneficiaries.

In addition, not all Medicare enrollees know about their HMO option. Upon becoming eligible for Medicare, enrollees learn only about fee-for-service Medicare and do not receive information about available HMO options.

The longer-term answer is that Medicare's overall program design must begin to keep pace with the evolution—and revolution—taking place in health care. Let me lay out for you GHAA's longer-term vision for bringing the Medicare program up to date.

Medicare must keep its vitally important promise of health care benefits for the elderly and disabled—objectives that reflect the key interests of beneficiaries, the government and taxpayers, and health plans.

Beneficiaries should be able to choose the form of Medicare coverage that best meets their needs, including both fee-for-service and HMO and other managed care options. Beneficiaries should have incentives to choose high quality plans that provide Medicare services in a cost-effective manner, and current and future beneficiaries should have the security of a Medicare program that is financially viable and sustainable for the long-term.

Government interests include predictable and fiscally responsible spending; assurances that the payment structure provides health plans and beneficiaries with appropriate incentives for high quality, cost-effective health care; and a program that encourages continuing improvement and innovation in health care and keeps Medicare up-to-date with the evolving health care system.

Health plan interests include a program with realistic incentives and opportunities to meet the needs of the Medicare population; predictable policy; and incentives to organize and deliver high quality care in a manner that minimizes Medicare and beneficiary costs—health plans should have the opportunity to attract and retain enrollment by keeping quality and service levels high and premiums competitive.

We believe that we must aim toward a system like that prevailing for some of the Nation's other large purchasers of health care—notably, the large employer purchasers including FEHBP. Individuals should have a choice of a wide range of qualified health plans under Medicare. Medicare, as sponsor, should set its premium contribution for Medicare benefits, set reasonable standards and monitor qualified health plans, and then let individuals choose among competing health plans—including fee-for-service (FFS) coverage. We have identified four initial policy areas that must be addressed, and would like to present our preliminary thoughts in these areas—standards for health plans; payments to health plans; benefits; and enrollment and marketing mechanisms.

Health plans: Beneficiaries should have a choice of health plans that meet comparable standards for quality, access, and solvency. The range of choices should include fee-for-service, as well as HMO and other managed care options.

Payments: Medicare payments to health plans should eventually be "market-based." Under such a system, qualified competing health plans should establish their premiums for Medicare benefits; and the government should set a contribution level in each market based on some percentile of a weighted average of those premiums. If the premium of the health plan selected by a beneficiary is greater than the government contribution, the beneficiary would pay the remainder. As with the current risk contracting program, Medicare payments to health plans should be risk adjusted. Therefore, it will be important to implement risk adjusters that are more sophisticated than those presently in use.

Benefits: All health plans seeking to participate would have to provide at least the Medicare benefit package defined in statute. Rules must be established for offering

benefits beyond the Medicare package, either as part of a plan's basic offering or in the form of supplemental benefits.

Enrollment/Marketing: The enrollment and marketing mechanisms must ensure that beneficiaries can make informed choices. In every market beneficiaries should receive information on all the choices available to them in a form that allows them to make comparisons between different types of plans and among different benefit offerings.

Open enrollment periods must be available in each geographic area during which beneficiaries can enroll without underwriting restrictions. However, a single, massive, one month open enrollment period for all beneficiaries would create logistical, administrative and service delivery nightmares. Given the huge size of the Medicare program, significant enrollment changes in such a 30 day period would pose serious problems for HMO's and other organized plans that must be prepared to deliver care to all those who enroll and therefore, would place service to beneficiaries at risk. In order to increase the availability of HMO's and other managed care options, open enrollment rules must be established in a way that allows them to optimally accommodate enrollment changes.

Mr. Chairman, we are mindful of the budgetary imperatives facing the committee—and the need for all of us to ask whether such changes will reduce the rate of increase in Medicare spending. We believe they will.

The strategy for controlling future Medicare outlays is not to seek just a one-time savings but to reduce the annual rate of increase. For the past 3 years, HMO premiums have increased more slowly than per capita costs for the Medicare program. For example, a GHAA survey reports that HMO premiums will decline 1.3 percent in 1995, whereas the Congressional Budget Office projects Medicare to increase about 10 percent a year until the end of the century.

Moreover, recent studies find that rather than shifting costs, the increased presence of HMO's leads to lower rates of increase in the fee-for-service sector. A soon to be published Georgetown University study reports that hospital costs for large hospitals located in high penetration HMO metropolitan areas increased 71 percent between 1984 and 1991 compared to 98 percent increases in metropolitan areas with low HMO penetrations.[7] A 1994 Urban Institute study concludes that for each 10 percent increase in the Medicare risk population's share of the Medicare market, per capita expenses in the Medicare fee-for service sector decline by 1.2 percent.[8] (Figure 2).

HMO's, moreover, achieve these savings under a system that subsidizes inefficiency. Beneficiaries and employees can choose more expensive plans and pay no more out of pocket for premiums. With a reorganized system of incentives whereby all stakeholders—patients, providers, and health plans—receive financial rewards for making efficient decisions, then the marketplace can produce unparalleled long-term savings.

The market-based system and payment methodology described above will be a critical element in achieving a lower rate of increase in Medicare spending as health plans compete to serve this population. Such a structure of competing managed care and other plans will provide the framework and incentives for all of us to make such a system work for the Medicare program—as it already does for many privately insured individuals.

One key question underlying all of this is the matter of risk selection. As I said earlier, we strongly support the development and implementation of risk adjusters appropriate to the Medicare population. But we take issue with a recent study that has biased the debate on this subject.

The HMO community believes that the Mathematica study came to an erroneous conclusion that the Medicare risk contracting program increases Medicare expenditures. First, the study did not make some of the adjustments necessary to ensure that fee-for-service costs are accurately compared to costs for beneficiaries in HMO's. It made no adjustments to the AAPCC for the working aged or individuals who receive their care from the Veterans Administration System. Since Medicare expenditures for the working aged and users of the VA system are substantially lower than expenditures for other beneficiaries and these individuals remain largely in the fee-for-service sector, the AAPCC estimates used in the study for annual reimbursements of fee-for-service enrollees are too low.

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[7] J. Hadley and D. Gaskin, "HMO Penetration and Academic Health Centers: Hospital's Mission," 1984-1991, Forthcoming in *The Proceedings of the Assoc. of Academic Health Centers,* 1995.

[8] W.P. Welch, "HMO Market Share and its Effect on Local Medicare Costs," in H.S. Luft, *HMO's and the Elderly,* Health Administration Press, Ann Arbor, Michigan, 1994, pp 231-250.

Second, Mathematica made no allowances for the spillover effect of HMO competition. W.P. Welch of the Urban Institute has estimated that for metropolitan areas with more than 25 percent of the population enrolled in the Medicare risk program, fee-for-service costs decline by 10 percent. Even Mathematica's econometric work found a spillover effect; however, the authors discounted this as implausible. We believe that as HMO's increase their market share and markets become more developed, the competitive effect of the fee-for-service sector will grow further.

Finally, as the HMO population has grown in the past few years, we believe that the characteristics of the HMO population become increasingly similar to those of the fee-for-service population. We observe recent surveys of the Medicare population that compare HMO and fee-for-service enrollees and find that the populations appear very similar. This was not the case a few years ago. We are involved in a number of studies testing the Mathematica conclusions.

Medicare is a vitally important program for 36 million aged and disabled Americans. In moving toward our vision for the future of this program, we ask that the Congress proceed in a planned, staged manner, and monitor and make changes as we go along. The "big bang" theory of implementation simply will not work, and will do a great disservice to the program.

However we must move forward in order to bring the Medicare program up to date so that it continues to fulfill its promise. As the program stands today, it will fall farther and farther behind the evolving health care system, placing it at increasing political and financial risk. We will be pleased to work with the committee and staff on both the long-term approaches and mechanisms to transition to such policies over a period of years.

In addition to developing the long-term vision and transition mechanisms, it is important in the short-term to make changes in the current program that will help expand choices for Medicare beneficiaries.

One such mechanism is the Medicare SELECT program—a demonstration program under which Medigap plans can use selected, preferred provider networks to meet the needs of enrollees. This 15 State demonstration program was extended at the end of the last Congress, but just until the end of June, 1995—less than 5 months away. It currently serves about 400,000 beneficiaries, and we urge the committee to take rapid action on Representative Johnson's bill (H.R. 483) to expand this option permanently to beneficiaries in all 50 States.

Second, we believe it important to make changes now in the existing Medicare contracting program. We strongly oppose short-term budgetary price setting "fixes" such as a floor or ceiling on payment rates—payments to HMO's will fall automatically as part of any budgetary reductions in provider payments or increases in cost sharing. GHAA has developed the following consensus recommendations regarding short-term changes in the contracting program.

—Develop statutory criteria in connection with waiving the 50/50 enrollment requirement for health plans.

—Change the rating areas for setting Medicare's adjusted average per capita cost (AAPCC) to MSA's, to make rates more stable and more reflective of service area-wide costs.

—Directly calculate Medicare fee-for-service costs in computing the AAPCC, rather than estimating total costs and netting out estimated HMO payments.

—Begin to structure demonstration projects to lay a foundation for the market-based restructuring of Medicare, such as by demonstrating market-based premium setting and government payment methodologies.

—Work on strategies for implementation of risk adjusters.

Mr. Chairman, as Congress and policymakers continue to consider restructuring the Medicare program to expand HMO and other managed care participation and choices, we strongly urge that the first priority be serving beneficiary interests and needs. Efforts to make the program more cost effective must be carried out within this framework. HMO's can be a critical element in developing an effective strategy to provide quality care to beneficiaries while at the same time decreasing the rate of Medicare cost escalation. However, they cannot bear the entire burden of solving the Medicare cost problem. Short-term, unrealistic efforts to generate savings through HMO's will be particularly damaging to the longer term effort, because they will harm the infrastructure needed to increase capacity to serve larger numbers of beneficiaries. Similarly damaging will be imposition of anti-managed care requirements, such as any willing provider provisions.

We are continuing to work out details of our long-term vision, as well as transition proposals, and look forward to contributing to the effort to redesign the Medicare program. We believe that an expanded role for HMO's and other managed care organizations holds great promise for beneficiaries, the government and health

plans. We would be pleased to work with you, and all of the members and staff of the committee, as you consider the future of the Medicare program. Thank you.

Mr. GREENWOOD. Thank you very much for those comments.

Do the three witnesses' schedules permit them to remain for a little bit longer? We appreciate their indulgence and thank them for testifying throughout the bells and whistles here.

We will recess until 2 p.m.

[Brief recess.]

Mr. GREENWOOD. We will reconvene the hearing now. I apologize to the witnesses for the additional delay. We were forced to resolve the weighty matter as to whether to adjourn in the middle of the afternoon and we decided not to.

I recognize myself for 5 minutes. Let me ask a question of Mr. Gradison.

Bill, during your many years of service on the Ways and Means Committee you were acknowledged by members on both sides of the aisle as our leading expert on the Medicare program. As you know, the House has voted for a balanced budget amendment. To reach that goal we need to substantially lower the double-digit growth rates in the Medicare program.

We do value your advice and counsel so greatly. I would like to give you an opportunity to give your overall thoughts on the state of the program and where you think that program should be going. I know that you have done that to some point in your testimony, but perhaps you could articulate some of the things that the members are not so sure they can.

Mr. GRADISON. Thank you, Mr. Chairman.

A lot has happened in the 2 years since I left. I was struck as a long-time member of the Budget Committee by the impact of health care inflation, specifically the increase in the cost level of the government health care programs on the projection of the deficit. It seemed pretty clear, at least at that time, that unless the level of Federal spending for Medicare and Medicaid, among others—there are other big health care programs, too—were brought down much closer to the general cost-of-living index, that a balanced budget would be virtually impossible to achieve.

I think what makes this so difficult is that the current discussion about restraining the rate of growth in Medicare and Medicaid follows a whole series of steps which have actually been taken to do that over a period of time. And it gets harder each time you do it. You have to make, in effect, even more difficult—they seemed tough at the time, but they are even more difficult now.

The concerns that we have had, which are reflected in my testimony, have to do with the possibility of cost shifting to the private sector from further—at least major additional restraints and provider reimbursement under Medicare and, for that matter, Medicaid.

I think it is fairly clear in the Medicaid area that—at least in quite a few States, that the level of reimbursement has affected access. And there are a lot of providers that just are not even willing to take Medicaid beneficiaries. That hasn't appeared to have happened yet, hope it never does, in the Medicare program. But I think the Medicaid experience should be a warning that there is some

point beyond which there may be an impact on access, if not on quality, from these payments.

While we are assuming—and I am assuming in my comments as well as in the prepared statement—that cost shifting would be the necessary impact and an adverse impact, there is another possibility which is that with the development of greater concentrations of buying power in the health care field, at least in some parts of the country, it might not be possible to cost shift. And if that proves to be the case then there could be a whole new set of circumstances which could arise, not alone as we have had in the past, because of the cost shifting to the private purchaser of health care or to the private health insurance system.

But I think we would then have to think about what would be the impact on health care, on hospitals, on physicians on their ability to continue to serve the public if the reduction in Medicare and Medicaid reimbursement did not offer a practical—if there were not the outlet of cost shifting to cushion the impact on their own bottom lines.

Mr. GREENWOOD. Thank you.

In your testimony, you stated that when Medicare penetrated a health care market in a given area it can exert a competitive cost containment effect on the entire marketplace. Could you explain the marketplace dynamics of this phenomenon?

Ms. IGNAGNI. Is that for me, Mr. Chairman?

Mr. GREENWOOD. Actually, it is for Mr. Gradison whose time has expired.

Mr. GRADISON. I am sure that others can do this better, but there is some evidence that when changes in the practice patterns occur in a community, perhaps driven by managed care, that they begin to have an impact on care in the traditional fee-for-service sector.

In other words—and the physicians could comment better than I—but a physician who develops a certain method of practicing and treating a particular kind of case in a managed care context I think is fairly likely to use that same approach in dealing with a patient whose reimbursement mechanism may be different.

Mr. GREENWOOD. Mr. Hastert.

Mr. HASTERT. Bill, I certainly welcome your testimony here. Could you explain, in a little bit more detail, the interaction between the Medicare/Medicaid and the anti-kickback laws of managed care arrangements?

Mr. GRADISON. Well, briefly, it is my understanding that, particularly with regard to Medicare Select, that these discounts—hospital discounts are permissible and are the main source of the savings which are passed on to purchasers. But that, because of the legislation that you are mentioning and some genuine uncertainty as to how it will actually be applied by HCFA and the Justice Department and others, that those same opportunities do not exist at the present time with regard to physician discounting.

But let me turn to others who can help me on this.

Mr. SPRENGER. At least in our State, the arrangements that we have with our physician providers or our hospital providers for our Medicare Select program is the same contracts that we have got for all of our HMO products throughout the entire State and so there is no differentiation with our products.

Ms. IGNAGNI. I would say, Mr. Hastert, there has been some discussion and concern about lack of safe harbors; and I think you are getting on that issue on the physician side, as both my colleagues have suggested. And I would suggest that it would be something that the committee might want to explore.

Some of the sense that we hear from our members is that they, because of the way the law now is, they are not able to employ some of the principles that they would in the Medicare sector as they do in their under-65 market, for example, or other products. So I think it might be something that as we want to move to more coordination and taking advantage of the inherent principles present in managed care to explore these issues and the way they would play out. And we would be delighted to assist the committee in doing that.

Mr. HASTERT. In the regulation of the Medicare supplemental insurance products, there has always been somewhat of an unresolved tension between the Federal regulators through HCFA and State regulators through the National Association of Insurance Commissioners and also the State insurance commissioners. Would you give us your thoughts on the proper roles for HCFA and the State regulators in regulating these products?

Mr. GRADISON. Mr. Chairman, my sense of it from your hearing today and, in addition, the hearing which the Ways and Means Committee had on the same subject is that there are basically two points of view about Medicare Select. Some people believe that Medicare Select should be regulated by HCFA pretty much the same way as risk contracts under Medicare are regulated. Others, including myself, believe that Medicare Select is effectively a variety of Medicare supplement or Medigap products and, therefore, should be regulated by the same folks who have the principal responsibility for regulating Medigap policies, which are the States.

Of course, I am aware that the broad guidelines—the plans A through J and so forth—are set down under Federal law, but pretty much it is NAIC and the States that regulate Medigap today and should continue as they are today to regulate Medicare Select which, as I said earlier, is merely a kind of Medigap policy.

Mr. HASTERT. Thank you. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Norwood is next.

And I wanted to apologize on behalf of myself to these panelists as well as those forthcoming because it is just terrible. I know we are being so very rude and crude to you. I know Mr. Gradison understands. I hope the rest of you do, too.

Mr. NORWOOD. Thank you, Mr. Chairman.

Mr. Sprenger, I would like to ask you a question if I may, please. What is the view of the physicians that you deal with with regard to Medicare Select? And what specific concerns or problems have they expressed? And under what circumstances have the majority of them left your Medicare Select networks?

Mr. SPRENGER. Our Medicare Select network is the same network that we use for all of our managed care products, so for the physicians who are comfortable in being in managed care networks they are exactly the same physicians that are a part of this Medi-

care Select. And so there is not a differentiation in terms of networks.

So our select product beneficiaries are getting the advantage of these physicians who have been very carefully selected, who buy into the discipline of a managed care system and who have developed the capacity to perform very well in a managed care delivery system. So we don't differentiate between the Medicare Select and the rest of our HMO products.

Mr. NORWOOD. In general, then, have any of your physicians left and had problems with the program? And, if so, why? Or what were their problems?

Mr. SPRENGER. No, in fact, our network is growing. It is not decreasing.

Mr. NORWOOD. So none of them have ever left?

Mr. SPRENGER. I can't say none of them.

Mr. NORWOOD. It is so small that you would not know what their complaint was anyway?

Mr. SPRENGER. There are those who get uncomfortable and—wanting to have total freedom and wanting to practice as they have in the past. They are uncomfortable in a managed care environment where you have oversights that are put in place by their peers, and they are uncomfortable with that, and so they leave.

Mr. NORWOOD. Do any of them feel that someone else is telling them how to practice medicine? Is that part of it?

Mr. SPRENGER. That is certainly something you hear a lot about, but we have worked hard at engaging our physicians in really establishing the practice parameters, the performance guidelines that we use, the credential standards that we use. And we think that, through that, we have been very successful in getting our physicians to feel a part of our network, not that the network is imposing these disciplines on them.

Mr. NORWOOD. Are there any incentives for the physicians to practice less than adequate medicine—financial incentives?

Mr. SPRENGER. No. In fact, just the opposite. We have very careful performance reviews, and that is from the customer, from the individual patient's perspective as well as other ways that—we have quality indicators and performance measurements. And so if someone is undertreating we are as concerned as if they were overtreating.

And there is no incentive. We do have a reward system that if we perform well that we can share some of those rewards with them. But part of this reward system is based on how satisfied our customers are and whether or not we meet our performance measurements.

Mr. NORWOOD. What does "perform well" mean?

Mr. SPRENGER. Well, we—for instance, recently, we just completed surveying all of our Medicare enrollees; and 98 percent of them were satisfied with the quality of care that they received; 98 percent were satisfied with the access to care. Which meant we had certain requirements: Did you get to see the doctor when you wanted to see the doctor? Ninety-eight percent would recommend our plan to a friend. One hundred percent were satisfied with the courtesy of the staff that they interacted with, a very high percentage

of satisfaction. And so we have a number of ways that we look at performance and judge our providers on that basis.

Mr. NORWOOD. In case you couldn't tell, those were written to be friendly questions.

Karen, one quick question——

Mr. SPRENGER. Very important questions, by the way.

Mr. NORWOOD. Tell me about the cost savings that we see in managed care. Not necessarily from the consumer or patient's point of view but just go over the cost savings compared to private practice or fee-for-service.

Ms. IGNAGNI. Thank you, Dr. Norwood, I would be delighted. I think that some of the recent studies really don't speak for themselves in terms of the compelling track record of the managed care plans, particularly HMO's versus fee-for-service.

There has been a consistent reduction and long-term pattern of reduction with respect to managed care versus fee-for-service. That has been determined by the Foster/Higgins study, which I guess the most recent—that was published several days ago. But also the Peat Marwick Company has been very much involved in the vanguard of tracking those data and has also longitudinal data to suggests definitely not a one-time proposition.

Finally, if you had a panel of major employers here they would tell you that their rates of increase now are virtually at the rate of zero. There is effectively no increase for this year. We are responding to what purchasers have required, at the same time maintaining satisfaction and performance and quality.

Mr. NORWOOD. Karen, that little red light says I need to say thank you very much. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. Waxman, would you like to inquire at this point?

Mr. WAXMAN. Thank you, Mr. Chairman.

I am pleased to welcome this panel. I am sorry I was not here to hear your testimony. It has been somewhat of a chaotic day.

Mr. Gradison, you stated last week before Bill Thomas's subcommittee that unless the overall structure of Medicare is radically altered there will always be a substantial Medicare fee-for-service population. As I am sure you know, some in Congress are looking at substantially modifying the Medicare program. They are looking at ways to reduce Medicare costs. Does HIAA support reductions in payments from the Medicare program to providers and plans in order to achieve deficit reduction?

Mr. GRADISON. Mr. Chairman, we do not. I expressed this earlier in my testimony. We are deeply concerned about the impact on the nongovernment programs through cost shifting to the extent that we feel that one of the major reasons for the number of uninsured in this country is the shift from the public sector to the private sector making private insurance less affordable.

Mr. WAXMAN. Do you know of any specific proposals that would generate substantial savings through the use of Medicare managed care where benefits would not be reduced and beneficiaries would not have large out-of-pocket expenditures?

Mr. GRADISON. I can't say that I do or I do not. We have not focused internally on this question of the total restructuring of Medicare. And, frankly, after our experiences in last week's hearing and

this week's hearing, we are going to turn our attention to that because I know we are being less than helpful in not being able to give you the kind of answer that you deserve to that fundamental question.

My Budget Committee experience suggests that one of the keys to this is coming up with scoreable savings. And in view of the uncertainties which were expressed earlier today by Mr. Vladeck and others about the impact of the present HMO/CMP option on overall Medicare spending, I think one has to approach this whole thing with a good bit of caution.

Mr. WAXMAN. One of the concerns about Medicare Select is the use of so-called age-attained premium rates. To what extent do your members employ such pricing and would you work with us to refine the bill so that these pricing practices would be prohibited by statute?

Mr. GRADISON. Mr. Waxman, some of our members use attained age rating, some of them use issue age rating. There are various practices out there. I think the key to this is making sure that when somebody purchases a policy they know what the options are and recognize that under certain of these options they are likely to face bigger increases in the future than under other options.

But I would not recommend to you that any particular option be totally outlawed. I think what is key is consumer information so that people could make intelligent choices about how to spend their money.

I would like to ask your permission, Mr. Waxman, to send up later some actual examples of how these numbers work out. I am not suggesting that there is no difference. But we have been struck how little the difference is in actual practice, and we would like to submit some numbers for your consideration.

Mr. WAXMAN. I would like to see it.

When we were working on health care reform legislation last year, HIAA opposed pure community rating in favor of permissible variations according to at least age and geography. Your testimony suggests that your members may wish to become more involved than they currently are in insuring the Medicare population. Would it be your position that insurance premiums could vary according to at least age and region?

Mr. GRADISON. Yes.

Mr. WAXMAN. Mr. Sprenger, moving away from the issue of Medicare Select to the issue of Medicare risk contracting, wouldn't it be true that an individual under a Medicare HMO who wanted to use a surgeon who was not part of the network would generally suffer serious financial penalty?

Mr. SPRENGER. Certainly they would have to pay if they went outside of that network under the risk contract. Under the Select Care contract you can choose to go outside of the network, but you have to pay beyond what Medicare basic pays.

Mr. WAXMAN. Thank you, Mr. Chairman.

Mr. BILIRAKIS. Thank you. Mr. Coburn—who is not here. Mr. Whitfield.

Mr. WHITFIELD. Mr. Gradison, I noticed in your testimony on page nine you refer to the Federal anti-kickback law which applied to the Medicare/Medicaid program, and that was an obstacle to ex-

panding managed care. Would you comment on that in addition to what you said here, please?

Mr. GRADISON. Congressman, I am not sure I can elaborate in a useful way much beyond what is in the testimony. But the main complaint that I run into is the difficulty of telling just what the law intends. And anything that you can do to help to clarify that or to speed up advisory opinions from HCFA or something of the sort would be extremely helpful.

My personal sense of it is that providers, for good and sufficient reasons, bend over backwards to avoid getting even close to the line because they are not sure where the line is.

Mr. WHITFIELD. It is basically a clarification issue then.

Mr. GRADISON. There may be more substantive issues as well. I am not suggesting that you change the law so much as you let people know what it means.

Ms. IGNAGNI. One of the issues that I may want to explore as you get into this question is that there is a safe harbor under the part A side, as you pointed out. There is the matter of part B. And what frequently individuals who are in this market point out is what could be done if you were able to employ the principles that you are able to employ for the under-65 market, namely the coordination of care. After all, that is what distinguishes the HMO style of practice from the fee-for-service style of practice is that coordination of care.

With the existence of the provision now there have been some concerns about how far a plan can go indeed in coordinating that care. And we would be delighted, Mr. Gradison, to work with you to help identify some of the problems and point out some solutions.

Mr. WHITFIELD. Okay. Also in your testimony—may I call you Karen? Because I am not sure how to pronounce your last name.

Ms. IGNAGNI. Yes, of course.

Mr. WHITFIELD. You indicated that established HMO's in Medicare programs now cannot have over 50 percent of their membership in Medicare/Medicaid. Is that true?

Ms. IGNAGNI. It is a 50-50 rule. Yes, sir.

Mr. WHITFIELD. Are you advocating a change in that?

Ms. IGNAGNI. We are advocating that a statutory waiver approach be explored so that plans that seek to have their membership above the 50-50 and vitiate that 50-50 law, that they have a process down at the department to evaluate that and make some decisions about it. Yes, sir.

Mr. WHITFIELD. Okay. One other quick question. Do you think there should be a program that provides an incentive for beneficiaries of Medicare to monitor the billing more closely than is done now? Right now, with third-party payment there is really no incentive to monitor at all.

Ms. IGNAGNI. Yes, sir. You are striking at an issue that is near is dear to my heart personally. My parents are in the Medicare program; and, frankly, they have a very, very hard time sorting out exactly what is going on and would be, I think, very enthusiastic about the prospect of being in a coordinated care network.

Of course in an HMO you understand there is very little paperwork. Really nothing more than the signing of the form. And that is one of the advantages, from the senior citizen perspective, not

having to track the billing and not having to get into the very difficult processes that are required.

Having said that, we think that there should be some leveling of the playing field in terms of standards as we have talked a lot this morning about standards on the managed care side. We would think that it would be prudent for this committee and others to explore ways to look at all the processes across Medicare both in the fee-for-service as well as managed care. And, again, we would like to provide some input on that if appropriate.

Mr. WHITFIELD. I would appreciate any input you might have.

And, Mr. Chairman, I waive the balance of my time.

Mr. BILIRAKIS. The gentleman's time has expired.

And we would request that from you, Ms. Ignagni, because when I get into my turn for questioning I am going to concentrate on fraud and abuse; and we can explore it a little further at that point.

Mr. Ganske.

Mr. GANSKE. Thank you. I apologize that I was voting and didn't get a chance to hear your remarks. So I hope that my questions are not running over ground that has been covered before.

Mr. Gradison, would you mind telling me what your congressional district was like when you served in Congress?

Mr. GRADISON. A bunch of great people. Once they sent me here, I thought they were terrific.

Mr. GANSKE. Was it rural?

Mr. GRADISON. The initial district was one of the smallest districts geographically in the country represented by a Republican. It had 175 square miles. Over time, it became more of a mixture. And, by the end, it was about 1,200 square miles; and it included five counties, two or three—two of which were purely rural and the third one was pretty close. It was about half and half between rural and urban. It included a medical center at one end. And it also included some counties with a single hospital where they were just struggling to stay open.

Mr. GANSKE. My district is like yours. I have a large metropolitan area and a large rural area. There are hospitals in my district out in the small towns in the rural areas that are currently losing 15 cents on every dollar they bill Medicare. They also happen to service a high percentage of Medicare patients, because these are areas where there are a lot of elderly people.

My question to you, Mr. Gradison, is this: Do you see a risk that the market power of large managed care networks will drive down reimbursement and force these hospitals in particular to do even more cost shifting, hospitals which have a higher percentage of Medicare patients and have less of an ability to cost shift? I mean, is that not basically what we are talking about in terms of managed care?

Mr. GRADISON. There has to be a balance from the purchaser's point of view to make sure that the service is still available at a good quality or they are not going to be able to satisfy their subscribers. So this isn't beat the price down to as low as possible. Or, if it is, it is not going to—it is going to be a very short-sighted approach.

The complaint I more often would hear was with the Medicaid level of reimbursements, not the managed care level of reimbursement, which was in general higher than the Medicare rate. I was struck by the concerns that often came to me from high Medicare hospitals—by which I mean hospitals which received 75 or 80 percent or more of all their revenue from Medicare. And they were saying they couldn't keep their doors open on this basis. Why? Because there were so few people left to shift to. And I think that is likely to happen.

In a managed care environment—let's take a case where managed care is the predominant method of reimbursement—there is not much place to shift to. There has got to be a realistic reimbursement rate for the service provider or the hospital is going to have to shut its doors, which is not in the interest of the managed care entity, obviously.

Mr. GANSKE. I understand.

Mr. Sprenger, is your plan basically a gatekeeper plan?

Mr. SPRENGER. No, sir. We have wide choice amongst our providers. We have—certain of our products do have a gatekeeper feature, but the bulk of them it is not.

Mr. GANSKE. In your plans that do have gatekeepers, do the gatekeepers have a withhold?

Mr. SPRENGER. They have an opportunity to have a reward if the plan does well at the end of the year, yes, sir.

Mr. GANSKE. I guess that is sort of like is the glass half full or half empty.

Mr. BILIRAKIS. Would the gentleman yield for a moment?

Mr. Sprenger, I understand you have a 3:30 flight. If you miss that, the next flight is at 7 o'clock. With our weather here, who knows about the 7 o'clock flight. If Dr. Ganske and others would be willing to relieve you, I certainly would be. If you are going to make that flight, you almost have to leave now.

Mr. SPRENGER. I would be happy to spend a couple more minutes.

Mr. BILIRAKIS. Excuse me for interrupting.

Mr. GANSKE. If you are a primary caregiver in a gatekeeper HMO who does not meet certain goals, you will not receive the withhold, is that correct?

Mr. SPRENGER. That is correct. If the performance is such, and the performance is based on some very important quality indicators. It is based upon customer satisfaction. It is based on the number of issues—if your question is——

Mr. GANSKE. Is it also based on financial considerations?

Mr. SPRENGER. I would say no from the point of view that we have developed appropriate care models in terms of what we expect that a patient will receive under certain circumstances. And that has been developed by the physicians themselves. And so, frankly, in our performance models, when we find out from the customers whether they are happy with the service, if someone has withheld treatment from someone, we are going to know that.

Mr. GANSKE. Are you telling me categorically that if a primary caregiver overutilize specialists to a certain dollar amount, that that would not be a factor in your consideration of whether they would receive their withhold or not?

Mr. SPRENGER. Absolutely. That is part of the performance evaluation, yes.

Mr. GANSKE. Do you think that is typical of the type of withhold arrangements that one finds around the country in gatekeeper HMO's?

Mr. SPRENGER. I think inherent in a gatekeeper HMO is that there certainly is focus on the gatekeeper to make sure that appropriate care is provided for the enrollee in the plan. But also to make sure that inappropriate things are not done. And so they are being held accountable as to the level of services that they are requiring.

Mr. BILIRAKIS. The gentleman's time has expired.

Mr. GANSKE. Thank you.

Mr. BILIRAKIS. Mr. Sprenger, you are certainly excused. Thank you so much for your patience.

Mr. Coburn.

Mr. COBURN. I just have one question that I would inquire of the panelists, and it really doesn't matter which one answers it. With the Medicare Select program as compared to other managed care patients, what is the profitability differential?

Mr. GRADISON. If it is agreeable, we would be glad to make some inquiries and answer that question. I truly don't know at this stage.

Ms. IGNAGNI. Dr. Coburn, as you probably know, there are some limitations that are set with respect to that issue. And we would be happy to provide more data on the specifics if you are interested in regions or plans or what have you.

Mr. COBURN. I am. As well as a physician, I am an accountant by training; and I know what the words creative accounting mean. And sometimes those numbers are valid and sometimes they are not.

Mr. COBURN. What I was leading to, more specifically, is this a very good business for managed care? I mean, you wouldn't be here testifying probably if it was not. And I guess that is what I am asking. Because I am really asking if, in fact, we are going to get savings for the Medicare patients I am going to be sure to see that the government participates in those savings and that we are not just providing extra benefits, because that is part of our job.

Ms. IGNAGNI. I would remind you, as you know, the Medicare Select is a supplemental product, which is very different than the Medicare risk product. And we would be happy to have some discussions with you on both.

Mr. COBURN. Thanks.

Mr. GRADISON. May I add that it is our sense that there are quite a few insurers who have stayed out of that market so far because of its uncertain status, 3 years and another 6 months. And, further, that if it were made permanent and went to 50 States that there would be a lot more competitors in the marketplace.

Now, on the one side you could argue they would not come in if they didn't think they could at least cover their costs. But if a number come in there is going to be keener competition as well with implications in terms of pricing and savings further down the line.

Mr. COBURN. I think your criticism of the timeliness of this program's exception is very valid. And I think that what my personal

worry is on doing a permanent extension and expanding it is that we haven't looked—we don't know what kind of plans that we are going to be looking to in terms of trying to help reduce this 14 to 15 percent of our gross domestic product in the future in this country.

And to lock ourselves into a program now and then come back to you in 12 months and say, I am sorry, and you would have made plans to do that. I am not saying yes or no. I am just saying there is some worry there in terms of trying to lock us into a position. And that is my concern at the time.

Ms. IGNAGNI. I would say the reason I made the remark I did when you noted that you were an accountant—as you know, there is some matter of what is an adequate test now of the performance of managed care. And I would hope that the committee would look broadly as you have the discussion differentiating on the Medicare supplemental side and the Medicare risk side, analyze the supplemental and Select as a supplemental and the risk as a replacement product.

This is not a replacement product, as you know, from the Medicare population in benefits. And I think oftentimes those two—and you can appreciate that the accountancy standpoint are confused, and I would hope that we could contribute to unraveling some of this and the data that we both are going to provide.

Mr. COBURN. I think the testimony shows that HCFA is also confused, and so that makes it even more complicated.

Mr. BILIRAKIS. To hitchhike onto that one, here we are basically having to make a decision whether or not to extend the program and how far to extend it, and yet the data that we expected last month from HCFA has not been forthcoming. And so it makes it that much more difficult on us.

Mr. Burr.

Mr. BURR. Thank you, Mr. Chairman.

I would assume from what I have heard that both of you would be in favor of the extension that we are talking about, maybe not as a permanent, with some reservations, but with an extension.

Bill, let me go back to something that you raised and that was the timeliness of HCFA signing off on some of the Medicare Select programs. What is that time frame?

Mr. GRADISON. I was actually referring to more the matter of the risk contracts where the same general principle would apply. It just seems to be a very slow process.

Mr. BURR. For the products themselves to be approved. I know that in the last conversation the administrator of HCFA I think implied that really these programs didn't get up and running until late 1992. Therefore, that that was the delay in their report to us because of inadequate information.

And to be very frank, as a businessman, I find it totally unacceptable that somebody could come in here with a date and not have a report in his particular case. And I will address that with him in a personal letter.

But are we going to learn anything from the HCFA report that we can't already find from the reports in the private sector about the success or failure of this program?

Mr. GRADISON. Congressman, I don't think so.

I also would point out to you that in Mr. Vladeck's testimony he has recommended a 6-month's extension but also has not assured you that you will have the report back in 6 months. All he said was before the end of the year. So you could find yourself in exactly the same situation where you are given a 6-month extension and at best you get the report and have not had a chance to analyze it. So 6 months doesn't help a lot.

I wanted to comment a little more broadly—the marketplace for the delivery of health care is changing so rapidly in communities around the country that there is an inherent problem in any study. They are looking at something that has happened already. They have to have a cutoff date for the collection of data, and by the time they make a recommendation to you the market in many cases may have changed and changed dramatically. And I think that is a problem in trying to make decisions.

Major purchasers of health care in the private sector are reviewing and revising their plans almost every year. I think it is safe to say every year because of these changes that are so rapid, and they are trying to learn from their mistakes and experiences.

Somehow, in the government programs, it is just a lot slower and as a result very little is changed. I made this point earlier—and it wasn't meant to be a wisecrack—that Medicare is the state-of-the-art 1965 health insurance program. And all I meant by that is that the benefit package—if Rip Van Winkle fell asleep in 1965 and woke up today and looked at Medicare, he would recognize the benefit package, which has changed very little; and he would recognize the delivery system, at least 95 percent of it, as to what it was then, too. That is not true of the private sector programs.

I guess it is inherent in a government program. Once you get started, equities grow up and not just on the part of the insurers. The providers and people have a stake in it, and that is why I think we are where we are today.

Mr. BURR. Has HCFA successfully marketed this program to the people who can take advantage of it?

Ms. IGNAGNI. I think the evidence suggests that beneficiaries are not aware of choices within the Medicare program. I don't think that this is a matter simply of Medicare Select. I think it is a matter across the board of the alternatives that are available. And I think perhaps it is timely and prudent to do some thinking about what might be done to make beneficiaries more aware of those choices.

Mr. GRADISON. I would just add, as a Medicare beneficiary but also as a Federal retiree, once a year as a Federal retiree we get all those choices, booklets letting you know. It is almost overwhelming. Medicare doesn't send me much of anything in terms of my options. You just keep doing what you are doing. They don't tell me of any managed care options or Medicare Select options or anything else that is available to me in the area where my family lives. In fact, I don't think that the government would let a private plan provide so little information. I bet the Labor Department might have a few comments on that.

Mr. BURR. Are you suggesting that you would like to bid for the administrative part of Medicare?

Mr. GRADISON. I am real happy that Bruce is there and not me.

Mr. BILIRAKIS. In the interest of time, I will not go into anything in depth. But you were in the audience when we talked about fraud and abuse earlier. The 10 percent figure was thrown out by the director of HCFA, and over the years at various hearings and meetings I have always heard the same sort of percentage. So maybe there is some credibility behind it all.

I am sure you both know providers out there who could be accused of fraud and abuse. I would like to think you do. Do you think that is a doable thing to try to concentrate on that area as, frankly, this committee is discussing and thinking about doing and really paring out most of that 10 percent? It could be more. It could be something less. What do you think in practice in the real world?

Ms. IGNAGNI. I think in the real world there is some real difficulties in getting your hands around exactly what is going on in the black box of fee-for-service. We in the HMO community have quite a lot of standards, as you know, in terms of identifying best practices, feeding back information about the latest in medical technology, efficacy, et cetera, and physicians working in teams along with other health care practitioners to meet the needs of members.

Once you move out of a world where you have a kind of coordinated care system, it is very, very difficult to, indeed, measure and find out what is going on. And I think that was one of the points that we have made in our submitted testimony, that we need to think about standards that would indeed level the playing field across all systems of care.

And we are very much interested in having this discussion, working with the committee and providing whatever expertise we can. Indeed, Mr. Waxman, I think was trying to get some of these issues when you made your observations about some of the issues that you are concerned about in Medicare Select.

I would respectfully suggest that, again, to look at only Medicare Select or only Medicare risk or only one particular product, whatever it might be, really doesn't give you, I think, the placement you want in terms of vetting the full set of these issues across all delivery systems. And I think it is now time for Congress to step up to the plate and think about leveling the playing field and examining this issue across the board.

Mr. BILIRAKIS. Bill, do you have anything you would care to add?

Mr. GRADISON. No, I think that was a very excellent response.

My overall feeling is that, while we are never going to eliminate greed, we can certainly reduce the fraud and abuse by working together. And I think one of the keys to this is perhaps a more open process of the sharing of information back and forth between the public and the private sectors in order to make this thing work. Because I would assume—I may be wrong about this, but I would assume that somebody who is defrauding a public program might just be defrauding private programs as well. Why should they stop?

Mr. COBURN. Will the gentleman yield? I would like to follow up with that. It does bring to mind what are we doing having the Federal Government running an insurance program? And the fact is that it does not do a good job in fraud and abuse. My contention is, as a practicing physician, most of the insurance companies I deal with know when I am trying to put the squeeze on them, and

I get this wonderful letter saying your price is too high or you have billed this too many times.

Can you imagine a private administration of Medicare totally outside of the government?

Mr. GRADISON. Most of the work of carriers and intermediaries is done by the private sector under contract with HCFA. They have been under considerable pressure, and justifiably so, to hold down their costs; and there have been instances where the contracts have been reassigned to others because the per claim costs has exceeded some number or other.

I have had a sense—or used to when I was more involved in this—I had a sense that within the contractor and intermediary community that, as the funds got squeezed down, the moneys available for the very thing you are talking about, the fraud and abuse, were often the ones that got left out—that is overstated—would be reduced proportionately. They still had to answer the claims and answer the inquiries and resolve the disputes.

And I think that—I don't want to suggest you haven't looked into that in the past, but I think that question of how it is done and how it is paid for is important.

Mr. BILIRAKIS. Well, reclaiming my time, I thank you both so very much. And we assure you—just in one moment—I assure you that this committee is going to try to hope to address that particular point along with everything else. If you have any suggestions, Ms. Ignagni or Bill or anyone else, submit them to us.

Mr. WAXMAN. I wanted to make the observation it is hard to outlaw greed. You can't do it.

But, second, you really can't try get your hands on this issue without setting some kinds of standards and enforcing them which means you need regulations to try to be sure that we can monitor this.

Ms. IGNAGNI. If I may, Mr. Chairman, I think one of the major opportunities now is that we have an opportunity to get out of these little boxes in which we are regulating various systems and think more broadly system-wide about the kinds of standards that are necessary to indeed level that playing field.

I think if there is any mistake that has been made in the past either at the Federal level or the State level is that we have approached this on a product by product and segmented products so that there is no common standard across products, and I think it is time to move in that direction.

Mr. WAXMAN. Mr. Chairman, as members are required to go in and out of the hearing today, I would like for the record to ask unanimous consent that all members have an opportunity to submit questions in writing to all the panelists and all the witnesses that appeared before us today so that we could get additional information.

Mr. BILIRAKIS. Without objection. And I would further ask unanimous consent to submit additional testimony and extraneous material in the printed record. Without objection.

You are excused. Thank you so much.

Because we have made the last two panels wait as long as I have—and our apologies for that—I would like to ask both panels to come forward at this time.

Panel four: Ms. Debbie Ahl, Mr. David Bradford and Ms. Mary Nell Lehnhard; and panel five: Ms. Gail Shearer, Ms. Bonnie Burns, and the Honorable Josephine Musser.

We can start with Ms. Ahl if we may. We need to change these name tags.

STATEMENTS OF DEBBIE AHL, EXECUTIVE VICE PRESIDENT, OLYMPIC HEALTH MANAGEMENT SYSTEMS, INC.; DAVID BRADFORD, CHIEF OPERATING OFFICER, FAMILY HEALTH PLAN COOPERATIVE; MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS/BLUE SHIELD ASSOCIATION; GAIL SHEARER, DIRECTOR, HEALTH POLICY ANALYSIS, CONSUMERS UNION; BONNIE BURNS, SENIOR HEALTH INSURANCE SPECIALIST, CALIFORNIA HEALTH INSURANCE COUNSELING ASSOCIATION; AND KEVIN T. CRONIN, WASHINGTON COUNSEL, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Ms. AHL. I am Debbie Ahl. I am the Executive Vice President of Olympic Health Management Systems.

To give you a bit of background, Olympic is a national health care consulting practice and a systems administrator. Our goal in the marketplace is to help providers transition to capitation and other types of reimbursement reform.

We are very involved in Medicare Select programs. We operate seven different programs under seven different insurers in six States. Some involve more than one insurer.

When you look at what we do, we basically do the whole program from developing the business plans to filing the policies themselves to negotiating between the providers and insurers, setting the plans up, implementing them and serving as a TPA under six different insurers. We serve as a general managing agency as well.

Finally, most important to our work is the fact that, as a TPA, we go tape to tape with the part B intermediary and in that function we collect data both on the Medicare direct payment to the providers as well as the supplemental insurance program. We contract with the hospitals and that is why they find Medicare Select so important in that it serves as a transitional tool for them in knowing what they need to do to better serve their marketplaces.

From the perspective of the provider, Medicare is definitely an important percent of the payer mix. As was mentioned earlier, it is generally 50 percent of the payer mix to as high as 80 or 90 percent in retirement meccas or rural areas, so the providers are attentive to what is going on there.

Providers very much understand the need to reform the Medicare system, and they want to be your partners in doing so. Their concern is that the change will come too dramatically and the systems will not be in place to allow the carrier to be managed in a manner it can help the marketplace transition without jeopardizing quality.

The only option currently available to hospitals participating in Medicare managed care is under the TEFRA risk contract program. Under aggressive risk contracting situations, the reimbursement rules all change. The hospitals' reimbursement on a base can drop as much as 50 percent. That is significant from the standpoint of the providers.

Medicare Select offers the hospitals an opportunity to really transition into Medicare managed care because, for example, the risk on the Medicare Select product is limited to the deductibles and coinsurance. The party deductible coinsurance represents, from a hospital perspective, as little as 5 percent of the DOG to as much as 10 percent. That varies from the size of the provider.

Medicare Select offers hospitals the opportunity to access data because they are developing relationships with insurers and insurers that normally may not collect the type of data that we collect for our clients. This type of data is essential for hospitals to take any leadership role in their market and in order to achieve and ultimately manage the system and to be able to operate functionally under a Medicare risk contract.

Medicare serves as a transitionary tool but also, for the seniors, it allows the seniors to test the waters without having to walk into the more restrictive measures of a risk contract. Seniors want more options like this in managed care. It is very much a hybrid product as opposed to fee-for-service or any true managed care program.

Olympic believes that Medicare will see cost savings from this program. We believe that the more managed care activities exist the more opportunity there is to save costs across the entire system. Once the volume of managed care is significant in any given market you will not see providers change their practice patterns based on the patient or the payer that they are seeing. It is not a good business decision at that point. They cannot revert to unmanaged care on a patient-by-patient basis.

Medicare Select offers an immediate opportunity to allow the market to continue to reform itself. It is very important that Congress send a clear message out to the market that Medicare Select is a program that is here to stay.

In terms of pilot parameters, a number of programs didn't get off the board. As I addressed earlier, in terms of the backlog in the State departments of insurance, sometimes it took as long as a year to get some of those products approved.

The other point is that the safe harbors were not made clear until well into the program. Medicare Select is complicated by issues referring to other supplemental insurance such as attained age rating and some of the other issues. It gets confused in terms of not being a true lock-in program. It does not need the same kinds of mechanisms that are required by the true HMO lock-in program.

The access to care—I can tell you from having worked with a number of State insurance departments that they truly are attentive to those measures; and they do micromanage those problems.

[The prepared statement of Debbie J. Ahl follows:]

PREPARED STATEMENT OF DEBBIE J. AHL, EXECUTIVE VICE PRESIDENT, OLYMPIC HEALTH MANAGEMENT SYSTEMS, INC.

My name is Debbie Ahl, I am an Executive Vice President for Olympic Health Management Systems, Inc., and I am honored to be here today.

Olympic is a national health care consulting practice and systems administrator (TPA). Our mission is to assist providers—and in particular, hospitals—to position themselves for capitation and other types of reimbursement reform. Olympic is involved in all types of PPO products including commercially insured and ERISA self-funded plans, but we have a particular area of expertise in Medicare Select. While my remarks today generally represent the perspective of health care providers, it

is important to note that Olympic is well versed in all aspects of this program. As the product line manager for a variety of Medicare Select models, Olympic is skilled in the development of business plans, in the regulatory process including filing and compliance, in contract negotiations, in reimbursement methodology and in the implementation of Medicare Select throughout the provider delivery system. In many States, we are even licensed as a managing general agency. As a TPA, we interface directly with Medicare fiscal intermediaries and collect all elements of data for Medicare and the supplemental portions of reimbursement. This data is maintained in a relational database and multi-variate reports are extracted on a routine basis. We serve as a TPA for six different insurers under Medicare Select with programs operational in seven States, often under more than one insurer. These insurers range from state-domiciled companies that have been established by the hospitals, to regional HMO's and health care service contractors, to national insurers that rank among the largest in the country. Olympic has filed more Medicare Select plans in more States under more insurers than anyone else in this country. We understand Medicare Select, including the complexities it has faced as well as the simplicity it offers.

Meaning no disrespect, Olympic believes that Congress is missing an opportunity to encourage provider innovation and accountability in the marketplace. The debate over Medicare Select has been needlessly complicated. The pilot parameters placed on the program in OBRA 1990, the inability of Congress to pass more than a 6 month extension last year, and the measures being debated today send a message of confusion to providers and insurers that are otherwise willing to support your goals of reducing Medicare costs. Medigap insurance is a private insurance product carved out of a government program. Medigap insurance is already subjected to the types of insurance reform Congress is seeking to apply to the commercial market. Medicare Select is a very simple program structured as a subset of the standard Medigap insurance regulations. It is not a lock-in HMO, but rather an incremental step towards more significant managed care. Medicare Select should be extended to all 50 States on an immediate basis without being dragged down in the more expansive issues of health care or insurance reform, or discussions regarding managed care that need not be applied to this hybrid product. Let me explain.

When Medicare was introduced in 1966, providers opposed what they saw as a movement towards nationalized medicine. Congress softened this blow by proclaiming, for example, that reasonable fees for physicians would be paid based upon area norms, and that physicians would be responsible for the direction of the quality of care provided. Those promises clearly are no longer manageable. Medicare was designed to ensure access to health care for a population on fixed or limited incomes. In 1966, there simply was no recognition, however, that the health care delivery system would be so successful in extending our life expectancy through access to technology and to services. The financing problems of caring for the Medicare population is now greatly compounded by the encroaching baby boom generation.

Unlike the commercial market which has experienced a great degree of penetration of managed care, Medicare remains amazingly untouched by such applications. For an acute care hospital, Medicare represents an average of 40 to 50 percent of the payor mix; as high as 70 to 80 percent for acute care hospitals in retirement meccas such as Florida. Providers are more than willing to assume increased responsibility relative to this market, on issues such as access, utilization, and reimbursement, however they have not always been provided with the tools to manage this change. Hospitals are genuinely concerned that the rules historically defined by government and by insurers will dramatically change and negatively impact the quality of care.

The only real application of managed care to the Medicare market to date is the TEFRA risk contracting program. Such programs are generally limited to high cost, densely populated areas where managed care commercial programs have been in existence for several years. When aggressive risk contractors enter a new market where the AAPCC is high and a zero premium can be offered, hospitals may be bullied into accepting per diem contracts at a rate less than half of that realized under the Prospective Payment System. This reimbursement fiasco is compounded by the very drivers of managed care which are designed to keep people out of the hospital until they are truly very sick. In other words, under a risk contract, the acuity of the patient increases while reimbursement is cut in half.

Medicare Select offers many of the tools that can help providers transition the market as an incremental step in Medicare reform. Unlike Medicare risk contracts, risk under Medicare Select is limited to the deductibles and coinsurance. Medicare Select can be regarded as a "mini" risk contract. To the provider, the deductibles and coinsurance represent a relatively small percentage of the cost of providing care to Medicare beneficiaries. Accordingly, health care providers are much more willing

to support this product line and to position themselves for greater innovation and more extensive Medicare reform such as a voucher system. Medicare Select offers hospitals the ability to access detailed utilization data that can influence provider behavioral modification. Insurers may or may not retain such data, as their traditional interest has been only in processing premium and paying claims. Even if such data has been collected, insurers typically are not willing to make such data available to the provider given its proprietary nature, confidentiality requirements, or the inability of extracting the data in meaningful reports. When hospitals form business relationships with insurers such as risk or preferred pricing under the Medicare Select program, they are able to access claims data across the delivery system. Access to such clinical information not only for the deductibles and coinsurance, but for all of the data elements extracting and adjudicated by Medicare fiscal intermediaries is an essential tool for providers to develop an optimally managed care system. Olympic currently services approximately 150 hospitals which are now accessing clinical information for Part A and Part B services through their relationship with the insurers and Olympic's involvement in the crossover claims exchange for the Medicare Part A and Part B intermediaries.

There is absolutely no doubt that managed care applications to the Medicare market can achieve significant savings for the beneficiaries, the providers, and the Federal Government. The providers are more than willing to partner with insurers and with the Federal Government in solving this dilemma. To achieve an optimally managed system, substantial changes must be made to the behavioral pattern of health care providers as it relates to access, utilization and reimbursement. These changes can not occur without substantial management and involvement from the health care providers, otherwise unsatisfactory outcomes will occur from the perspective of all parties, but most importantly, for the consumer. Medicare Select provides the tools that providers need in transitioning the market from an unmanaged care system to an optimally managed care system.

Medicare Select is a valuable tool for incremental market reform from all perspectives. From that of the Medicare beneficiary, Medicare Select offers lower premiums, sometimes as much as 40 percent less, in exchange for commitment to use a network of providers. Unlike the "lock in" provisions of a Medicare risk contract, Medicare Select is much friendlier to the seniors who may have no previous experience with a managed care plan. It represents a way for seniors to dip their toe into managed care without getting all wet. For example, Medicare Select policies are required to pay benefits for services rendered in an emergency, when a senior is traveling out of town, or whenever the network cannot offer services needed. And, regardless of in network or out of network use, Medicare direct benefits stay in place. Even in a case of absolute disregard for the restrictions of the policy, a senior would only be subject to paying out of pocket deductibles and coinsurance while his/her Medicare benefits stay intact.

As I discussed earlier, from the perspective of both insurers and providers, Medicare Select offers an incremental approach to managed care, a stepping stone upon which to build more in depth managed care product lines.

From the standpoint of the Federal Government Medicare Select represents opportunity for future savings. True, it has yet to prove any significant cost savings. This is primarily a result of the fact that Medicare Select's networks tend to be limited to the hospitals which can most significantly impact the premium. Physicians tend not to be contracted providers for two reasons. First, there is no safe harbor for physician participation in either risk or discount for their Part B deductibles and coinsurance. HCFA routinely sends out fraud and abuse bulletins which scare physicians away from any such arrangements. Secondly, physician contracting takes significantly more time and effort than most insurers are willing to invest in network development for what is still a pilot project. Medicare Select has not cost the Federal Government any money. Furthermore, it has the ability to reduce Federal costs because it encourages use of managed care programs. The more managed care applications that exist in the Medicare arena, the more providers will change their patterns of behavior. Once changed for any payor, provider patterns of behavior do not differentiate between patients. In other words, improved practice patterns that result from one payor's requirements result in improved practice patterns for all payors. Truly, the Federal Government should encourage any and all such avenues of managed care activity.

To allow Medicare Select to achieve its original objective of decreasing Medicare costs to the Federal Government, Congress must send an unequivocal message to the provider and to the insurance industry that it encourages managed care in both the private and public sector. Medicare Select, and all Medicare supplement insurance, is a private sector carve out of a government program. Medicare Select is a subset of standard supplemental insurance regulations. These policies are already

governed by the type of reform measures Congress is seeking to impose on commercial insurance plans. Medicare supplement regulations already address limitations on preexisting conditions, portability, guaranteed renewal, open enrollment for individuals just turning 65, and restrictions on agent compensation. Congress should be careful not to complicate Medicare Select with additional measures that really pertain to supplement insurance. For example, the extension and expansion of Medicare Select does not need to be contingent on the debate over community rating. Community rating applies to Medicare supplement insurance. If Congress wishes to enact such reform on the Medicare supplement industry, it will automatically apply to Medicare Select. The expansion of Medicare Select does not need to be contingent upon the debate regarding open enrollment. While the concept of a singular month enrollment and disenrollment is absolutely nonsensical in nature, the resolution of this issue should be kept separate from the message Congress delivers to the market regarding the future of Medicare Select.

The expansion of Medicare Select should not be jeopardized by the debate as to whether HCFA should provide oversight to the state insurance departments relative to managed care issues. The States have adopted the NAIC model regulations regarding Medicare Select. This regulation includes the requirement for a Plan of Operations to be filed, it includes provisions for quality insurance, it includes provisions for grievance procedures. It even includes a provision for Federal oversight if the States don't do their job. Don't complicate Medicare Select by making it what it is not. It is not a lock in HMO. It does not require the level of oversight nor the level of documentation that is required of a true lock in plan. Remember that Medicare Select is limited to deductibles and coinsurance. Quality within the delivery system is not jeopardized by a 5 percent reduction from fee for service.

For Medicare Select to achieve its objectives, I would leave you with these three points.

1. Send a clear message to the market that Medicare Select is here to stay and that the existing state standards for the regulation of these policies are adequate for the role Medicare Select serves as a hybrid product. By removing the pilot parameters, you will have encouraged insurers and providers to join together to invest in the research and development for these product lines and to help transition Medicare beneficiaries into these plans and into future innovations such as the Medicare voucher system. Don't wait until the 100th day. Don't wait for comprehensive reform. Don't complicate a simple program.

2. Give physicians a safe harbor under Medicare Select. Allow Medicare Select to achieve its objectives through the ability to structure more comprehensive networks that include physicians. HCFA clearly has the opportunity of auditing for compliance at any time. Use this vehicle relative to quality standards and utilization monitoring.

3. Allow for innovation within Medicare Select by encouraging the state Departments of Insurance to use the existing innovative benefits clause. Allow this vehicle to be used for preventative health care services, or to structure nominal office copays that can assist in conditioning utilization patterns of Medicare beneficiaries. Allow this provision to be used to enhance the benefits of the Medicare Select policies.

In conclusion, Medicare Select is a viable program that offers Congress the immediate ability to show the market that you can get something done. It is the epitome of an incremental step towards both health care and insurance reform, and it allows the market to assist in solving a dilemma that Congress seems to be claiming as its own. Medicare Select is a private sector carve out of a government program. Let the private sector step up to the plate and assist the government through market based reform. Medicare Select is not a lock in plan, it does not require the level of oversight nor regulation that is required by an HMO risk contract. Medicare Select has done no harm, and it has the potential to do a great deal of good. Don't make it what it is not. Let it be what it is meant to be.

STATEMENT OF DAVID BRADFORD

Mr. BRADFORD. Good afternoon. I would like to take the opportunity to thank you for the chance to speak before you.

I am David Bradford, the Chief Operating Officer of Family Health Plan Cooperative in Wisconsin; and I am here to encourage your support for the extending of the Medicare Select program indefinitely into the future.

From our perspective, the Medicare Select program works; and all our members want it. They want it because it provides comprehensive benefits not otherwise available in our market. It provides a choice from among many available in our market. It provides high satisfaction. And from the peculiar perspective of my HMO it provides an opportunity for us to continue to care for our members as they age into the Medicare age bracket whereby we can continue after many years to care for them into their older age.

Family Health Plan is a federally qualified, staff-model, not-for-profit, consumer cooperative HMO serving roughly 110,000 members in the Milwaukee and surrounding communities and employs more than 100 physicians exclusively devoted to the care of our membership. We own and operate seven full service health centers. And, as a consumer cooperative, our membership serves on the board of directors and elects the directors of the plan annually.

We serve commercial Medicaid and Medicare beneficiaries. Roughly 3,600 Medicare Select members are enrolled in the plan.

In Wisconsin, HMO's offer one standard Medicare Select plan, offering comprehensive services with no copayments and no deductibles. Plans must provide a minimum level of prescription benefit coverage, but it may be provided in full. Family has always provided 100 percent coverage for prescription drugs to Medicare beneficiaries without copayment or deductible.

The program works. With Medicare Select, it is like the commercial point-of-service enrollment product. Members have the option of obtaining care from any Medicare-certified provider and having most of those services covered or they may provide all of their care through our system and enjoy a broad, comprehensive first-dollar coverage. That includes 100 percent coverage for emergencies when they are away from home. It also includes checkups, flu shots, mammography and other preventive services and screenings.

We have measured the performance of our plan with regard to this population and have found that we provide five times more pneumovax immunizations against pneumonia to our elderly population. We provide 3.5 times more flu shots to our elderly population. And in our older adult population we provide more than three times the mammographic screening of the communities at large.

Even with such broad scope of benefits our rates are much lower than the cost of indemnity coverage, up to 40 percent lower than indemnity policies which offer no drug coverage at all. I would like to say that again. We offer first dollar drug coverage at a price 40 percent less than competing indemnity policies which offer no drug benefit whatsoever.

By choice, we maintain a single premium rate regardless of age. So a 50-year-old who is disabled pays the same premium as a 65-year-old or an 85-year-old. Ours is a community-rated program.

In Medicare Select programs, we manage patient care. Our plan is built on primary care physicians, and we emphasize prevention and early intervention instead of crisis-oriented care. With our approach, patients who might otherwise require hospitalization are getting well and staying home.

And our experience is—despite an industry nostrum that the provision of full prescription benefits attracts significantly more ill pa-

tients, our experience is that we have 20 percent fewer hospital days for an equivalent population. That, I think, implies strongly that, despite an adverse selection, that Medicare risk—a Medicare Select program can save the Federal Government its costs.

Medicare Select offers adequate consumer protections as well. First, our mission as a not-for-profit consumer cooperative places our focus on our membership. As I mentioned earlier, members serve on our board of directors. Our Medicare members, who are among the majority of our members at our annual meetings of our cooperative, are also among those who elect those directors and then in turn establish policy for the plan.

We have built member advocacy into our organization, including an outreach program for orientation of new members to instruct them as to their benefits, to educate them as to their obligations under the plan. And, in fact, well before their effective date of enrollment we would have completed a complete medical history, introduced them to their primary care provider of choice——

Mr. BILIRAKIS. Would you sum up, please?

Mr. BRADFORD. [continuing] and evaluate them for any additional care. We have adequate grievance procedures, and our marketing and other policies are reviewed by the Insurance Commissioner of the State of Wisconsin.

Our experience is that 98 percent of our membership reenrolls when given the opportunity. Our principal concern, I think, in suggesting that you extend the Medicare Select benefits to our membership in the long term, is so that we can continue to serve our membership as they age, which many of our members have expressed an interest in.

We ask that you permit Family Health Plan to remain a health care provider selected by thousands of citizens in our area by making the program permanent, and we will be happy to provide whatever assistance to promote the extension of this popular program.

[The prepared statement of David Bradford follows:]

PREPARED STATEMENT OF DAVID BRADFORD, CHIEF OPERATING OFFICER, FAMILY HEALTH PLAN COOPERATIVE

Mr. Chairman and members, thank you for the opportunity to appear before you today. I am Dave Bradford, chief operating officer of Family Health Plan Cooperative in Wisconsin. I am here to encourage your support for extending the Medicare Select program indefinitely into the future. From our perspective, the Medicare Select program works, and our members want it.

Family Health Plan is a federally qualified, nonprofit, staff-model HMO serving roughly 110,000 members in Milwaukee and surrounding communities. We own and operate seven full-service health centers. As a consumer cooperative, our members serve on the board of directors and elect the directors of the plan annually.

We serve commercial, Medicaid and Medicare beneficiaries. Roughly 3,600 Medicare Select members are enrolled in the plan, which we've offered since 1993.

In Wisconsin, HMO's offer one standard Medicare Select plan, offering comprehensive services with no copayments or deductibles. Plans must provide a minimum level of prescription drug coverage, but may provide full coverage. FHPC has always offered 100 percent coverage of prescription drugs to Medicare beneficiaries—again without copayments or deductibles.

With Medicare Select, members have the option of obtaining care from any Medicare-certified provider and having most of the service covered, or remaining within Family's providers and enjoying broad, comprehensive coverage.

That includes 100 percent coverage of emergencies when they are away from home. It also includes check-ups, flu shots, mammograms and other preventive services and screenings. And 100 percent coverage of prescription drugs.

Even with such a broad scope of benefits, our rates are much lower than the cost of indemnity coverage—up to 40 percent lower than indemnity policies, which offer *no* drug coverage.

By choice, we maintain a single premium rate, regardless of age. So the 50-year-old who is disabled pays the same rate as the 65-year-old and the 85-year-old. Ours is a community-rated program,

In the Medicare Select program, we can manage patient care. Our plan is built on family practice medicine. We emphasize prevention and early intervention instead of crisis-oriented care. With our approach, patients who might otherwise require hospitalization are getting well and staying home.

First, our mission as a nonprofit consumer cooperative places our focus on the members. As I mentioned earlier, members serve on the board of directors. Our Medicare members, who are among the majority of members at our annual meetings of the cooperative, are also among those who elect the directors who establish policy for the plan.

We've built member advocacy into our organization. We employ membership advisors (advocates) at each of our seven health centers. In addition, two Medicare beneficiaries serve our Medicare population as Medicare assistants. Our Medicare members are encouraged to contact these people with comments, concerns, complaints. They work to help members, resolve conflicts and obtain information.

All have access to Family Health Plan's grievance process, and they can also file grievances with the state Office of the Commissioner of Insurance.

Wisconsin provides adequate regulatory oversight of the Medicare Select program. The insurance commissioner reviews all policies before they are approved for sale, and all marketing materials. Members have a 30-day free look at policies after they purchase.

As a Medicare Select HMO, we must have on file with the commissioner a plan of operation. We must provide proof that our plan is providing adequate access to care, and that we have a vigorous, ongoing quality assurance program.

Our primary concern is the future of members now enrolled in Family Health Plan. Although our current Medicare members could remain enrolled in Family Health Plan, the people who would otherwise "age into" Medicare Select would be without coverage through Family Health Plan. As a staff-model HMO, we have provided care to some of these people for as long as 16 years. By failing to renew this program, you would be telling us to disrupt their well-established relationships with their physicians, and their health plan, and to go find a new doctor through a less comprehensive, more costly health plan.

Our plan prides itself on making it easy to remain a member of Family Health Plan. That is one of the reasons we serve commercial, Medicare, Medicaid and individual populations. Members have expressed a feeling of satisfaction and security knowing that Family Health Plan will provide for them after they become eligible for Medicare and leave their employers' plans.

We ask that you permit Family Health Plan to remain the health care provider selected by thousands of citizens in our area. Make the Medicare Select program permanent. We will be happy to provide whatever assistance is needed to promote the extension of this popular program.

Mr. BILIRAKIS. Mrs. Lehnhard.

STATEMENT OF MARY NELL LEHNHARD

Ms. LEHNHARD. I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross/Blue Shield Association. The Association represents the 68 Blue Cross/Blue Shield plans.

We have been very involved in the Medicare program since its beginning. Our plans administer the vast majority of the program—90 percent of part A and 75 percent of part B. And I would note, following up on an earlier point, we have a very good track record of detecting fraud and abuse. We call them program safeguard activities in the Medicare program.

For every dollar invested in the safeguard activities we save $14 for the government. But there has been a steady record of cutbacks in the safeguard activities over the last several years, and we would be glad to work with this committee on ways to restore those

moneys. We know they can produce significant savings for the government.

In addition to being very involved in administering the Medicare program, we are also the largest provider of Medicare supplemental insurance and Medicare Select benefits. We are the largest managed care provider in the country. Forty percent of our 68 million subscribers are in network products.

We believe there is great merit to expanding the managed care options available to Medicare beneficiaries—and I stress the word options. Today, we focus our recommendations on the first step we think Congress can take to achieve this, and that is making Medicare Select permanent and available in all 50 States.

About 400,000 subscribers, Medicare beneficiaries, are now enrolled in Medicare Select in 15 States, and about 350,000 of these are in Blue Cross and Blue Shield programs. In exchange for very substantial savings in the Medigap premiums, beneficiaries enroll in these plans and seek care from a network of providers. These networks operate very much like the private sector point-of-service programs, very popular programs that many of you may have in your own Federal employee's program.

Unlike a Medicare HMO product where beneficiaries are literally locked into the HMO and can't go outside the HMO and have a service paid for, individuals in the Medicare Select keep the basic coverage. They can go anywhere at any time and be fully paid under the traditional program. But when they do use the network—and the incentive to use the network is that they will get their Medigap payments, the cost-sharing amount under Medicare, paid in full.

Medicare Select is a valuable option for seniors. The program offers significant savings, up to 40 percent in many of the States. In fact, Consumer Reports says that 8 of the top 15 highest value products in the country are Medicare Select products.

Medicare Select is also highly rated by our subscribers. Two Blue Cross and Blue Shield surveys indicate that scores for Medicare Select are equal to or higher than the fee-for-service products. And we think it is also a valuable option for the Federal Government.

These Medicare Select networks are evolving into more sophisticated managed care programs that will result in savings as the utilization of the basic benefits is better managed. Preliminary data from two Blue Cross/Blue Shield plans indicate that utilization is lower and the government outlay is less for care provided by network hospitals and physicians.

And I would make a very important point here today. Given much of the discussion today, because of the way that Medicare Select is structured, the government does get all the savings from the beneficiaries using more efficient networks. All of the savings go to the government. And the government is not exposed to any risk of the government paying more than they should have, as under the HMO's. There is absolutely no downside risk for the government under the Medicare Select program.

And, again, I want to highlight that since the program will expire in June, notices will start to go out in April; and legislation must be enacted before April to extend this program without disruption.

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If the program is allowed to lapse, premiums will increase for enrollees; and the networks will deteriorate as physicians drop out because they see no future in the program. And I think, very importantly, it will be a very strong signal to the private sector that the Federal Government is not a good business partner.

Mr. Chairman, members of the committee, this is a program that is working. Everybody says it is working. It saves Medicare money. It is flexible. Beneficiaries can go out of network any time and still get their coverage. And I stress there is no risk to the government. And we urge you to extend the program before April.

[The prepared statement of Mary Nell Lehnhard follows:]

PREPARED STATEMENT OF MARY NELL LEHNHARD, SENIOR VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD ASSOCIATION

Mr. Chairman and members of the committee, I am Mary Nell Lehnhard, Senior Vice President of the Blue Cross and Blue Shield Association. The Blue Cross and Blue Shield Association (BCBSA) is the coordinating organization of the 68 independent Blue Cross and Blue Shield Plans across the country. Collectively, Blue Cross and Blue Shield Plans provide coverage to 65 million Americans.

Blue Cross and Blue Shield Plans have been involved in Medicare since its inception in 1966 in several different ways. Blue Cross and Blue Shield Plans administer the vast majority of Medicare claims; are the largest provider of Medicare supplemental insurance and, more recently, Medicare Select PPO benefits; and now provide HMO benefits as Medicare risk contractors.

When Medicare was created in 1965, it was modeled on the private health system. While the private system has changed dramatically in the last 30 years—from fee-for-service to one dominated by managed care systems—Medicare has largely remained a fee-for-service program.

Blue Cross and Blue Shield, a name many associate with fee-for-service, is now the largest managed care provider in the country. More than 40 percent of the Blue Cross and Blue Shield enrollment nationwide is now in managed care programs—PPO's, HMO's and point-of-service programs.

We believe the Medicare program can and should make better use of managed care as a purchaser of the Medicare benefit package. Today, I would like to focus my comments on one particular way that Medicare can introduce flexible Preferred Provider Organizations to its beneficiaries—Medicare Select.

The Blue Cross and Blue Shield system supports the immediate extension of Medicare Select to all 50 States on a permanent basis.

About 450,000 Medicare beneficiaries have chosen to enroll in Medicare Select programs in 15 States. Approximately 370,000 of these beneficiaries are enrolled in Blue Cross and Blue Shield programs.

These programs provide significant value to both Medicare beneficiaries and the Federal Government and should be made available nationwide.

The Medicare Select demonstration program was first authorized in 1990 when Congress enacted reforms of the Medicare Supplemental insurance (commonly referred to as Medigap) market. This legislation created 10 standardized Medicare supplemental benefit packages that could be sold by private insurers. These supplemental packages cover expenses not paid under Medicare, such as deductibles, coinsurance, prescription drugs and preventive services. The 1990 law allowed managed care networks (PPO's and HMO's) to offer these benefits to Medicare beneficiaries in 15 States for 3 years.

The 1994 Medicare technical amendments, enacted in the closing minutes of the 103rd Congress, extended these 15-State demonstration programs for 6 months. The 3½ year time frame ends June 30, 1995.

While the intention of Medicare Select was to expand managed care options, the 15-State demonstration actually forced the closing down of some existing network programs in the other 35 States. These cost effective programs should be available to beneficiaries in all States.

Medicare Select provides a third option under Medicare. Under Medicare, beneficiaries have two basic options: traditional fee-for-service and HMO coverage. Of the 36 million Medicare beneficiaries, more than 2.5 million people are enrolled in Medicare HMO's. About 70 percent of the 33 million Medicare beneficiaries enrolled in the fee-for-service program purchase Medigap coverage to cover expenses not reimbursed under Medicare. Medicare Select provides beneficiaries the option of pur-

chasing their Medigap benefits at significant savings from Preferred Provider networks.

In exchange for substantial savings in Medigap premiums, beneficiaries are encouraged to seek care from a select network of hospitals and/or physicians. Medicare Select networks are not restrictive and operate much like "point-of-service" options. Full Medigap benefits are paid when network providers are used. Unlike a Medicare HMO product, individuals retain basic Medicare coverage and can still go out-of-network for Medicare benefits. For example, under most Medicare Select Plans, beneficiaries pay no Part A deductible ($716 in 1995) for hospital care received by network hospitals; however, they could seek care from hospitals outside of the network, but must pay the deductible. Medicare Select is supplemental coverage—not primary coverage. Under Medicare Select, Medicare is continuing to reimburse providers under normal Medicare rules and all the regular Federal Medicare safeguards, such as review by Peer Review Organizations, are applied to this program. This is very different from the Medicare HMO program which offers primary coverage, "replacing" standard Medicare benefits and has the HMO risk contractor fully "at risk" for the care.

As supplemental coverage, the Medicare Select program is regulated by the States under minimum standards set by the Federal Government. Medicare Select is subject to all the same rules as Medigap, including a 6-month open enrollment period when a beneficiary first turns age 65, pre-existing condition limitations, minimum loss ratios, solvency standards, etc. In addition, Medicare Select Plans are subject to rules specifically designed for network products: networks are required to offer sufficient access, have an ongoing quality assurance program and provide full disclosure of network requirements at the time of enrollment. If the Medicare Select carrier also offers a fee-for-service Medigap product, the Select plan must offer conversion at any time, with no strings attached. All of the Blue Cross and Blue Shield Medicare Select Plans offer conversion to a fee-for-service Medigap product.

This program provides the best of both worlds for Medicare beneficiaries—increased quality at reduced monthly premiums. We believe Medicare Select offers the best possible use of private markets—the government still maintains a role in oversight and funding, but the government saves money because of beneficiaries' purchasing choices and the private marketplace's downward pressure on cost and utilization.

Medicare Select is a valuable option for Medicare beneficiaries. The program:

—Offers significant savings to Medicare beneficiaries: The price of Medicare Select policies are 10 to 40 percent less than the price of regular Medigap products offering the same exact benefits. This could result in a savings of up to $25 a month or $300 a year, a very significant savings for people on fixed incomes.

—Highly rated by Consumer Reports: The August 1994 Consumer Reports rated Medicare Select policies very high. Of the top 15 best valued products in the country, 8 were Medicare Select.

—Highly rated by subscribers: Several Blue Cross and Blue Shield Plans annual survey of subscriber satisfaction indicates that seniors are highly satisfied with their Medicare Select policies. In fact, two of the largest Plans report that Medicare Select subscribers score equal to or higher than the fee-for-service alternatives.

—Provides flexibility to consumers: As mentioned earlier, unlike the Medicare HMO option, Medicare Select subscribers retain their basic Medicare benefits if they choose to seek care from an out-of-network provider.

—Allows newly eligible Medicare beneficiaries the option of continuing enrollment in current managed care plans: An increasing number of Americans are now receiving their employer-provided health benefits from managed care plans. Medicare Select allows Medicare beneficiaries to continue enrollment in their current managed care arrangement when they retire.

—Protects consumers from physician balance billing charges: Many Medicare Select Plans involve a physician network which requires physicians to take Medicare assignment for all Medicare Select participants. By seeking care from network physicians, subscribers are protected from balance billing costs.

Medicare Select Plans are evolving into more sophisticated managed care networks that will result in savings to the Federal Government.

Medicare Select will result in savings to the government because the networks that are central to the success of managed care plans include providers whose practices are higher quality and lower cost than the norm. If the market is allowed to evolve, more and more managed care features will be employed, creating more savings, flexibility, and choice.

In evaluating current Medicare Select Plans, Congress needs to recognize that the state of managed care varies significantly across-the-country. For example, in Cali-

fornia, managed care has had a long history and is the common form of health care delivery. In other areas of the country, managed care is just beginning to evolve.

The sophistication of Medicare Select Plans' management of their networks reflects, to a large extent, the maturity of managed care in their individual marketplace. High managed care penetration in an area generally translates into more sophisticated management practices.

Increasingly, Medicare Select Plans are selecting network providers based on performance and quality criteria; adding utilization and quality control standards beyond what is required by Medicare; and profiling providers and providing them feedback on their practice patterns. Even when the networks are fairly broad, many of these management practices are included in the program.

Blue Cross of California's (BCC) Medicare Select program is an example of a program that is reducing costs for the Federal Government. Enrollment in BCC's program totals approximately 90,000 Medicare beneficiaries, with 24,000 members enrolling in the last 12 months. BCC's Medicare Select network is made up of carefully selected hospitals—including some of the State's premier institutions such as Cedar-Sinai and Stanford—and 40,000 physicians. Early BCC data for 1993 found that savings accrue to the government when seniors use in-network providers. BCC found that:

—The cost of medical services per admission for network providers was 20 percent lower than for non-network providers.

—The average length of stay for network providers was 50 percent lower than for non-network providers.

Another example is the Medicare Select program operated by Blue Cross and Blue Shield of Florida. Blue Cross and Blue Shield of Florida's Select program also includes a select network of hospitals and physicians that were recruited based on their cost and quality performance. The program has been well received by its subscribers. The price of their Medicare Select program is approximately 25 percent lower than the fee-for-service equivalent Medigap product. Based on the Florida Plans's annual customer satisfaction survey, overall satisfaction with the Medicare Select options were 91 percent, higher than the customer satisfaction index for both the HMO and the fee-for-service alternatives offered by the Plan. Providers also seem to be satisfied with the program. The number of physician resignations is quite low, and of those, the majority are for retirement and relocation. No hospitals have resigned from the program. Preliminary data from Blue Cross and Blue Shield of Florida's experience with Medicare Select indicate lower utilization rates than for its traditional Medigap products.

Other Blue Cross and Blue Shield Plans that participate in the Medicare Select program include Blue Cross and Blue Shield of Alabama, Blue Cross and Blue Shield of Arizona, Blue Cross and Blue Shield of Illinois, Associated Group in Indiana, Southeastern Group, Inc. in Kentucky, Blue Cross and Blue Shield of Minnesota, Blue Cross and Blue Shield of Kansas City, Missouri, Blue Cross and Blue Shield of North Dakota, and Community Mutual Insurance Company in Ohio.

In addition to providing savings to the Federal Government, the Medicare Select option helps introduce managed care and competition to Medicare. Select offers a lower priced alternative to seniors who live in areas where an HMO is not available.

Legislation to extend Medicare Select must be enacted by April to avoid any disruption in the program. If action isn't taken by April, the Health Care Financing Administration will need to notify States to prepare for closing the program. Medicare Select Plans would have to notify their beneficiaries and participating providers that the program may close June 30. While current enrollees could remain in the program, the program would be closed to all new Medicare beneficiaries after June 30.

Allowing the program to expire would result in:

—Significant increases in premiums for current enrollees. Without the addition of new enrollees, premiums will increase for current Select subscribers.

—Loss of lower cost option for new Medicare beneficiaries.

—Deterioration of the Medicare Select network if participating providers decide to leave the network when new enrollment ends. Providers may feel that it is not advantageous to continue in a program with declining enrollment. This has a domino effect since subscribers will tend to be unhappy and leave a program when their providers no longer participate.

We believe Congress should act quickly to make the Medicare Select program permanent and available in all 50 States. This is the thrust of the bill introduced by Congresswoman Johnson (H.R. 483) and cosponsored by about 100 members. This program is providing significant benefits to seniors by affording them the option which is the number one choice of most under 65 Americans—Preferred Provider

Organizations. We believe the program will also prove to provide savings to the Federal Government.

In Medicare's future, the Select program has an even more important role to play among the expanded range of health plans from which beneficiaries will choose.

The need for permanent authority is critical to the willingness of several Blue Cross and Blue Shield Plans and others to offer Medicare Select products even in the authorized demonstration States.

Once seniors can rest easy that this popular program is safe, we can assess potential ways to improve it. We would be pleased to work with the committee on this and other health care issues. Thank you for the opportunity to be here today.

Mr. BILIRAKIS. Thank you.

Ms. Shearer.

STATEMENT OF GAIL SHEARER

Ms. SHEARER. Consumers Union appreciates the opportunity to present our views on Medicare Select. We have spent several years monitoring the Medigap market and working to improve protections for seniors who buy Medigap policies. We worked in support of this subcommittee's efforts to fix the problems in this marketplace, efforts that culminated in the historic enactment of OBRA 1990 Medigap reforms. These reforms made it easier for consumers to comparison shop among so-called Medigap policies designed to fill in the gaps of Medicare.

This testimony addresses one aspect of the Medicare supplement insurance market, Medicare Select. We believe that there are several major problems with the Medicare Select market, and we urge caution when it comes to making Medicare Select a permanent program.

First, there are pricing games. Medicare Select policies often offer cheaper premiums to begin with but, because of a system of so-called attained age pricing that many policies use, premiums will rise steeply as the policyholder gets older. Most of the Medicare Select policies top rated by Consumer Reports magazine were attained, age-rated products. Congress should not lock in or expand a program which perpetuates this deceptive pricing practice.

Second, we are concerned about illusory cost savings. Medicare Select premiums are often low but typically at a cost to other Americans. Insurance companies that write Medicare Select policies typically don't pay the deductible to the hospital that the other Medigap policies are designed to pay, but the hospital still has to cover its costs. The result is it shifts costs to other patients and insurers.

And, third, the problem is the Medigap maze. The idea behind OBRA 1990 Medigap reforms was to allow consumers to make comparisons among plans. But the Medicare Select program doesn't afford that goal. It adds a layer of confusion by forcing consumers to balance initially lower premiums against restricted freedom of choice of doctor or hospital.

We believe it is premature to expand the program. Preliminary analysis of the program indicates that, so far, it has not been successful in reducing costs or attracting substantial interest from insurers or consumers.

We recommend that Congress, first, require all States to do what several States have already done, community rate their Medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans and, hence, level the playing field among in-

surers. Alternatively, condition the State's ability to participate in Medicare Select to a State-wide requirement of community rating for the Medigap market.

Second, require a 6-month open enrollment period for all consumers who were previously enrolled in Medicare Select and want to switch to fee-for-service plan.

Third, limit the extension of Medicare Select to a 2-year time period that would allow for study and analysis—that is currently under way by HCFA—of cost savings and quality control. Postpone expansion of the program to additional States until the studies are complete and regulatory adjustments can be put in place.

In conclusion, research done to date indicates that the Medicare Select demonstration program has not achieved its goals. It has resulted in a marketplace in which premium pricing games distort the true cost of the policy. It shifts the costs to other consumers. Few insurers and few consumers have participated.

In many Medicare Select States, regulation of this product has fallen between the cracks of different regulatory agencies—is it insurance or is it managed care?—leaving consumers without the protections they need. Congress shouldn't expand the program but should take steps now to fix what is broken—specifically the pricing structure and the need for open enrollment—and await further study results before locking the program into place.

With respect to Medicare Select, we urge to you proceed with caution. This morning, Congressman Pomeroy described the initial demonstration project, 15-State, 3-year limit, as oversight overkill. We believe that expanding it to all 50 States and making it permanent without even studying it and fixing what is clearly broken would be oversight underkill, and we urge to you reject this course of action.

[The prepared statement of Gail Shearer follows:]

PREPARED STATEMENT OF GAIL SHEARER, DIRECTOR, HEALTH POLICY ANALYSIS, CONSUMERS UNION

Consumers Union[1] appreciates the opportunity to present our views on the issue of Medicare Select. We have spent several years monitoring the medigap market and working to improve protections for seniors who buy medigap policies. We worked in support of this subcommittee's efforts to fix the problems in this marketplace, efforts that culminated in the historic enactment of OBRA-90 medigap reforms. These reforms made it much easier for consumers to comparison-shop among so-called medigap policies, which are designed to fill in the gaps in coverage left by Medicare. We continue to believe that these reforms serve as a valuable model for future legislation in areas such as long-term care insurance and regulation of a supplemental market in future health reform.

This testimony addresses one aspect of the Medicare supplement insurance market—Medicare Select. Medicare Select is a cross between traditional Medicare supplement (or medigap) policies and HMO's. In return for initially cheaper premiums, consumers agree to obtain care within a designated network of doctors—in order to

[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of *Consumer Reports,* its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, *Consumer Reports* with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers Union's publications carry no advertising and receive no commercial support.

be reimbursed for the costs covered by the policy. (Medicare still provides coverage, regardless of whether the provider is in the Select network.)

We believe that there are several problems with Medicare Select. In the big picture, Medicare Select represents a diversion from the tough issue of reining in Medicare costs—through managed care or other steps. Pressing questions that this subcommittee must address include: to what extent do HMO's—which limit seniors freedom of choice of doctor—truly save costs (or merely select the healthy risks)? Is there adequate quality assurance in Medicare risk contracts? Is there sufficient ability for consumers who do not feel well-served by Medicare HMO's to pick up traditional Medicare/medigap coverage? Is it possible—and fair to seniors—to ratchet down the Medicare budget without achieving cost control in the private insurance sector (in the context of overall health care reform)?

There are several major problems with the Medicare Select market and we urge caution when it comes to making Medicare Select a permanent program:

—Pricing games: Medicare Select policies often offer cheaper premiums to begin with. But because of a system of so-called "attained age" pricing that many policies use, premiums will rise steeply as the policyholder gets older. Congress should not lock-in or expand a program which perpetuates this deceptive pricing practice.

—Illusory Cost Savings: Medicare Select premiums are often low, but at a cost to other Americans. Insurance companies that write Medicare Select policies typically don't pay the deductible to the hospital that other medigap policies are designed to pay. But the hospital still has to cover its costs. The result: it shifts the cost to other patients—and their insurers.

—The Medigap Maze: The whole idea behind the OBRA-90 medigap reforms was to allow consumers to make kitchen table comparisons among plans. But the Medicare Select program doesn't forward that goal. Medicare Select adds a layer of confusion by forcing consumers to balance initially lower premiums against restricted freedom of choice of doctor or hospital.

We believe that it is premature to expand or make permanent the Medicare Select program because of these problems and others described below. Preliminary analysis of the program indicates that so far it has not been successful in reducing costs or even attracting substantial interest from insurers or consumers. We recommend that Congress:

—Require ALL States to do what several States have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a State's ability to participate in Medicare Select to a State-wide requirement of community rating for the medigap market.

—Require a 6-month open enrollment period for all consumers who were previously enrolled in Medicare Select.

—Limit the extension of Medicare Select to a 2-year time period that would allow for study and analysis (that is currently underway by HCFA) of cost savings (vs. cost shifting) and quality control. Postpone expansion of the program to additional States until the studies are complete and regulatory adjustments can be put in place.

We elaborate on our concerns and recommendations below.

Medicare Select policies often use an "attained age" pricing structure, which *Consumer Reports* says is "hazardous to policyholders." Various letters and comments regarding Medicare Select have noted that *Consumer Reports* found that 8 of the top 15 Medigap products were Medicare Select. But this tells only part of the story. Five of the eight policies mentioned use an attained-age pricing structure. *Consumer Reports* stated that: "Attained-age policies are hazardous to policyholders. By age 75, 80, or 85, a policyholder may find that coverage has become unaffordable—just when the onset of poor health could make it impossible to buy a new, less expensive policy. Take, for example, an attained-age Plan F offered by New York Life and an issue-age Plan F offered by United American. For someone age 65, the New York Life policy is about $114 a year cheaper. But by age 80, the buyer of the New York Life policy would have spent a total of $5,000 more than the buyer of the United American policy."[2]

The attained-age pricing structure allows companies to bait consumers with low premiums in early years, and then trap them with high increases in later years. Standardization of the medigap market resulted in price conscious consumers, with the effect of facilitating a trend away from community-rated policies and toward attained-age rated policies. The percent of Blue Cross-Blue Shield affiliates, for example, that sell attained-age policies grew from 31 percent in 1990 to 55 percent in 1993.

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[2] "Filling the Gaps in Medicare," *Consumer Reports,* August 1994, p. 526.

Ten States have recognized this market dynamic and have taken steps to protect consumers either by requiring community rating for this market or by banning attained-age rating. These are Arkansas, Connecticut, Florida, Georgia, Idaho, Maine, Massachusetts, Minnesota, New York, and Washington. Four of these States—Florida, Massachusetts, Minnesota and Washington—are part of the Medicare Select demonstration program.[3]

Recommendation: Require ALL States to do what several States have already done: community rate their medigap market to eliminate the hazardous pricing structure used by many Medicare Select plans (and level the playing field among all insurers). Alternatively, condition a State's ability to participate in Medicare Select to a State-wide requirement of community rating for the medigap market.

The purpose of Medicare Select was to cut health care costs through coordinated care networks that increase the use of utilization review and management controls, often through PPO's. It was expected that enrollees would be restricted to a subset of providers. But the experience shows that often there is no restriction of providers. There is little coordination or management of care in Select plans.[4]

Medicare Select premiums may be low for the wrong reasons—because these policies shift costs to others by not covering all the costs that traditional medigap policies must cover. Medicare Select companies often negotiate with providers to eliminate the payment of Part A deductibles. Insurers have indicated that the discounts of the Part A deductible by participating hospitals is the most significant source of premium savings available in Medicare supplements.[5] This means that hospitals get less reimbursement from Medicare Select carriers. It does not mean that the hospital's costs are lower, so cost shifting to other patients (and their insurers) is inevitable.

Before extending Medicare Select to additional States (or for a substantial time period), we urge you to study further why Medicare Select premiums are often low. Are they cutting premiums for their policyholders merely by shifting costs to other payers? Another issue of concern to us is whether the Medicare Select markets in each State are truly competitive. We understand that in California, for example, there is only one key Medicare Select carrier (Blue Cross).[6] A study prepared for HCFA found that three-fourths of Medicare Select enrollees have policies from affiliates of three Blue Cross and Blue Shield plans (in Alabama, California and Minnesota), hardly an indication of a truly competitive marketplace.[7] We urge you to study the level of competition in this marketplace, recognizing of course that traditional medigap policies do compete with Medicare Select policies.

Recommendation: Limit the extension of Medicare Select to a 2-year time period that would allow for study and analysis (that is currently underway by HCFA) of cost savings (vs. cost shifting) and quality control. Postpone expansion of the program to additional States until the studies are complete and regulatory adjustments can be put in place.

A key goal of the medigap reform legislation that was included in OBRA-'90 was to provide true consumer choice of medigap policy by standardizing policies, thereby simplifying the choice. In light of the minimal role the Medicare Select products have made in this marketplace, we question whether the expanded complexity offers consumers significant benefits. Consumers (in Medicare Select States) must decide between Medicare only, Medicare risk plans, Medicare cost plans, health care prepayment plans, Medicare Select plans, and traditional Medicare supplement policies. They can't even consider which of 10 standard packages to consider until they have made this choice.

Furthermore, insurers have indicated that the 10 standard medigap plans are appropriate for fee-for-service (traditional) medigap policies, but not for network Medicare Select products.[8] If Medicare Select necessitates an additional one or more standard policies, then simplicity is further undercut.

Medicare Select was included in OBRA-90 medigap reform legislation as a demonstration program. Medicare Select was established with the hope of achieving

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[3] It is premature to evaluate the impact of the combination of Medicare Select and community rating, since two States (Massachusetts and Washington) are new to Medicare Select and since community rating requirements are fairly recent.

[4] "Evaluation of the Medicare SELECT Amendments—Case Study Report, RTI Project No. 32U-5531, prepared for Office of Demonstrations and Evaluations, Health Care Financing Administration, U.S. Department of Health and Human Services, February 10, 1994, RTI, p. XX-3.

[5] RTI, p. xi.

[6] Three other plans: Foundation Health Plans; National Med; and Omni Health Plan have been approved but had minimal enrollment, that totals less than 500. [RTI, p. IV-17]

[7] p. ix.

[8] RTI, p. xiii.

goals such as reducing health care costs (both for the Medicare program and consumers) and reducing the paperwork burden on consumers (since Medicare Select plans relieve consumers of the paperwork burden inherent in filing claims). It should not be made permanent until studies of its effectiveness have been completed. The preliminary report (February 1994) paints a picture of Medicare Select that is hardly complimentary. A tiny percent of people eligible have enrolled; a small fraction of insurers participate; cost savings appear to be superficial only and may be cost-shifting in disguise; the market is highly concentrated; Medicare Select regulation often falls between the cracks in state regulatory departments.

Some specific findings that should set off alarms to put on the brakes—not rush ahead with a permanent expansion—include:

—Some States (e.g., Arizona) have found that market response has been poor and that beneficiaries tend to migrate back to traditional plans.[9]

—Several States that were selected for the program could not get it off the ground and dropped out.[10] Others have had no applications for Select plans.[11]

—When studied by RTI, only 2.5 percent of eligible Medicare enrollees selected Medicare Select policies, and most of these "rolled over" from pre-standardization products. It appears that consumers are not, in general, attracted to Medicare Select policies.[12]

—Nor are insurers attracted to the Medicare Select product: only 10 percent of HMO's and medigap insurers in Select States offer Medicare Select policies, with even interest in some States.[13]

Recommendation: Congress should delay expanding and making permanent the Medicare Select program until further study results are available. It should not be made permanent without fixing the elements that are broken.

Medicare Select is fraught with questions about regulatory authority. It is not unusual for a State's insurance department to regulate fee-for-service medigap coverage, but another state department (e.g., Department of Public Health or Department of Corporations) to regulate Select products. It is very possible that Medicare Select policies get lost in the regulatory cracks where authority for traditional insurance and HMO's is split. This confusion has even led to approval of plans (as Select) that deviate from the OBRA '90 standard plan designs.[14]

Medicare Select consumers need regulatory protection. For example, consumers switching out of Medicare Select need protection. Consumers who choose a Medicare Select option must use providers in the designated network in order to get medigap coverage. The NAIC model regulation provided protection to consumers who elect Medicare Select but then wish to change to traditional medigap policy. Companies were required to offer such consumers a policy with similar benefits, without underwriting. But this provision has a loophole—consumers have no assurance of such an offer if the Medicare Select company does not offer a traditional ("fee-for-service") medigap policy.

In the event that Congress decides to end the Medicare Select program, either now or in the future, then consumers who have Select policies when the program is ended will need protection. Without new entrants in their pool, their premiums (in closed blocks of business) would spiral upwards. They will need the protection from such an open enrollment period.

Recommendation: Congress should require that all policyholders who wish to switch out of Medicare Select be eligible for an open enrollment period (regardless of which company they select) in order to protect them against being locked into a Medicare Select plan that they do not like.[15] This protection would actually help to promote the Medicare Select option because consumers would have a safety valve if they are dissatisfied. If Congress chooses to end the Medicare Select program, insurers should be required to extend an open enrollment period to Medicare Select policyholders. We urge the Congress to study carefully the regulatory experience and analyze where regulatory authority for Medicare Select is best housed.

Medicare Select policies keep premiums low by negotiating lower reimbursement schedules with providers (mostly hospital), providing discounts to policyholders. On average Medicare pays doctors and hospitals about 59 percent of what private insurers pay for the same services. If (in the future) Medicare Select coverage is nego-

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[9] RTI, p. III-6.
[10] E.g., Oregon and Michigan. RTI, p. XV-1.
[11] E.g., Illinois. RTI, p. XV-3.
[12] RTI, p. ix.
[13] RTI, p. ix.
[14] See, for example, RTI, p. IV-9, IV-10.
[15] In Florida, Select insurers are required to offer at least a basic Plan A in a non-Select form, providing partial protection for people who wish to switch out of Select plans. One side-effect: this provision makes it infeasible for HMO's to offer SELECT plans.

tiated downward (e.g., providing Select policies with Part B discounts also), providers will get even less. At some point, the cumulative impact of lower reimbursement has got to have an impact on quality of care that patients receive. This could occur when providers withdraw from providing services to consumers, or when they cut corners (such as patient time) due to the lower reimbursement levels.

Recommendation: Congress should study the impact of further negotiated discounts for providers before rushing to extend the Medicare Select program.

In conclusion, research done to date indicates that the Medicare Select demonstration program has not achieved its goals. It has resulted in a marketplace in which premium pricing games distort the true cost of the policy. It has not achieved cost savings, but merely shifts costs to other consumers. Few insurers and few consumers have participated. In many States, regulation of this product has fallen between the cracks of different regulatory agencies (is it insurance or managed care?), leaving consumers without the protections they need. Congress should not expand the program and make it permanent, but should take steps now to fix what is broken (the pricing structure, the need for open enrollment) and await further study results before locking the program into place. With respect to Medicare Select, we urge you to proceed with caution.

Thank you for considering our views.

Mr. BILIRAKIS. Thank you.

Ms. Burns.

STATEMENT OF BONNIE BURNS

Ms. BURNS. Thank you, Mr. Chairman.

I am a private contractor. I train older volunteers in California to help other seniors with their Medicare benefits and health insurance benefits.

I am also—I train a lot of those volunteers. I also do individual counseling myself. I have been doing that for 18 years. I have been a consultant to our California insurance department, and I was also on the working group as a consumer representative when the policies were standardized into the 10 standard policies.

Someone said earlier that our insurance system is employer-based, and it is. And it used to be that employers provided health care benefits for people after retirement.

But much has changed in the 18 years that I have been doing this. And one of the things that has changed is that, as employers are not offering retiree health coverage in near the numbers that they used to, those that are, are increasing premiums, increasing the copayments, increasing the deductibles and in some cases dropping benefits entirely.

In California, we have a number of defense contractors who as a result of the loss of those contracts are now dropping large numbers of retirees into the private health insurance pool. Many of those people are well-past 65 and many with health conditions.

Base closures are causing some of the same things to happen. In addition to which many of the people who retired from the military and got their care at the military bases never enrolled in part B of Medicare, and they are now having to do so and pay a penalty because they didn't enroll when they were 65 and then, in addition, having to also pay the cost of a Medicare supplement.

One of the things that concerns me about people on Medicare is that health care costs are one of the things that push them into poverty and subsequently into the Medicaid program. A lot of you have heard about people spending down to Medicaid in nursing homes because of the high cost of long-term care.

But there are many more people who spend down in the community due to the increased costs of health care that they pay for out of their own pocket. Because—remember that Medicare doesn't pay for all of their health care. It does not cover it all in the first place and leaves cost sharing to be done by them.

One of the most significant costs to seniors, particularly as they age, is the cost of prescription drugs. And almost every private health insurance plan sold to individuals under Medigap has underwriting for that drug benefit unless the person is in the 6-month open enrollment period.

And seniors are now spending approximately 24 percent of their disposable—of their income on health care costs. And so seniors know better than anyone else what health care costs because they are the ones most likely to pay it. And as they age and their income and their assets go down, those health care costs have a more profound effect on their ability to stay out of poverty.

The OBRA reforms are only 2 years ago. Remember that, even though it passed in 1990, that it wasn't implemented in the State until 1992, fairly late in 1992. There isn't a lot of experience with this yet.

The 10 standard plans have just remarkably changed the market for seniors. They can now do really side-by-side comparison of the benefits. They know what they are buying, and the only thing they are comparing is the price and the service from the companies.

The risk contracts are very, very difficult to compare because they are a lot like the old Medigap policies were. There are an awful lot of fringe add-on benefits on a risk contract. They are all written differently. Some have premiums. Some don't. Some like the drug benefits. A company may offer premium-free drug benefits, but they may only be $300 a quarter or $400 a year or $700 a year, and they may only be for drugs on the list. People don't have the information that they need to be able to choose Medicare risk contract. That kind of information isn't available.

And under the select program there are three States that are the biggest Medicare Select companies, have the most enrollees, and there are some problems with the Select as well as you have heard already, I have concerns about cost shifting. I am very concerned about safe harbors for part B because I wonder what the benefit a person would be buying if there is no payment of the part A deductible, no payment of the part B deductible and a much smaller payment of the part B coinsurance, then what is the premium for. So I have some concerns about that.

The way I think you ought——

Mr. BILIRAKIS. Would you summarize, please.

Ms. BURNS. Yes. I think there is an easy fix for attained age and that means you would not even have to tinker with the pricing and that would be to just level the playing field for all Medigap policies and require all Medigap policies, including Select, to have an annual open enrollment that would allow the companies to price the products accurately. It would give people the option of moving in and out of whichever system works best for them, and those policies would then compete on a similar basis with the risk plans.

I would like to see the Select program extended for 6 months and some of these issues that we have talked about today addressed in legislation.

Thank you.

[The prepared statement of Bonnie Burns follows:]

PREPARED STATEMENT OF BONNIE BURNS, SENIOR HEALTH INSURANCE SPECIALIST, CALIFORNIA HEALTH INSURANCE COUNSELING ASSOCIATION PROGRAM

My name is Bonnie Burns and I am a private contractor. I train older volunteers in the California HICAP program who help other seniors with their Medicare benefits and Medigap insurance including Medicare Risk plans.[1] I also contract with several agencies to provide expert counseling and technical assistance for people with complicated Medicare claims or insurance problems.

I have worked on a daily basis with seniors for the last 18 years and I am well acquainted with their problems, their fears about health care costs, and their benefits. Over the years I have seen tremendous changes in Medicare and in the range of options to supplement Medicare. The standardization of MediGap insurance was a welcome and revolutionary change for seniors who can now easily choose the benefits they need, and readily compare those benefits from several different companies. Medicare Select and Medicare Risk programs are additional options for beneficiaries to combine managed care with their Medicare benefits.

The private health insurance market works best when people have good information for decision-making. California has both a high number of Medicare beneficiaries and beneficiaries enrolled in Medicare Risk programs and Medicare Select, so our experience may be instructive as you consider these programs. Since others who previously testified have focused on the value of these programs and their successes, I would like you to know how these programs need to be strengthened.

Good comparison information is basic to the whole notion of managed care in the private market. Alain Enthoven once described managed completion as "value for money competition." Consumers who enroll in HMO's trade their unrestricted choice of health care providers in return for assurances of quality medical care in a managed care setting at a lower cost. To make good choices consumers need good information about a plan and its operation.

The GAO noted in a recent study that most experts agree that there is a need for "Report Cards" to evaluate health plans, and that standardized indicators and formulas for calculating results need to be developed.[2] This is especially true for Medicare Risk plans because consumers are unable to make meaningful comparisons between existing competing HMO plans.

The first question a senior asks when seeking counseling is, "Which plan is the best?" The 10 standard MediGap policies make it very easy for consumers to compare benefits and costs. But, HMO's sell a bewildering array of benefit packages with varying premium and copayment costs. There is no information generally available that would allow consumers to compare anything else.

Just as an example of the difficulty of comparing benefits, one HMO offering a prescription drug benefit in a northern California county offers a higher maximum annual benefit than most. But the benefit is calculated on the list price of drugs, while another HMO offering a lower annual benefit calculates their maximum benefit on a discounted price. What appears to be a higher annual benefit could actually be used up earlier than the plan with a lower annual maximum using a more favorable method for calculating the benefit. This information is not readily available to a consumer at the time of application and presents a confusing and misleading comparison of benefits. Seniors are often not even aware that some HMO's restrict their drug benefit to a limited list of drugs until after they fill their prescription. Considerable variation between plans and benefits is the rule rather than the exception, and side by side comparison is impossible.

Marketing, advertising, and plan documents need to clearly spell out the benefits and restrictions of the plan.

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[1] HICAP, the Health Insurance Counseling and Advocacy Program, is a state-wide program administered by the California Department of Aging. Twenty-four contracting agencies utilize more than 700 volunteer counselors to provide free insurance counseling and assistance to seniors. In FY 93-94 HICAP served 100,000 individuals and saved Medicare beneficiaries $3,428,486.

[2] "Report Cards Are Useful but Significant Issues Need to be Addressed", Report to the chairman, Committee on Labor and Human Resources, U.S. Senate, September 94, GAO-94-219.

Marketing strategies in an intensely competitive market like California's can result in inadvertent enrollment by overeager plan representatives; inappropriate enrollment of people with cognitive impairment; enrollees who give up existing employer group coverage with more comprehensive benefits out of ignorance of the difference in coverage; and too little information for consumers to understand the Medicare lock-in provisions. Each of these produces excessive disenrollments when errors like this are discovered. Each of these instances results in excessive costs and paperwork for the HMO, extra claims processing costs for the carriers and intermediaries, enrollment mix-ups for the Medicare program, and delays in claims paid to providers under the fee for service program.

The adult daughter of an 83 year old woman recently enrolled her mother by mail in an HMO risk program after seeing ads for premium free coverage. Her mother had recently been hospitalized with a stroke and because she also has Parkinson's disease was receiving Home Health care several times a week. The literature sent by the HMO clearly stated that Home Health Care was a covered benefit, and that acceptance for coverage was guaranteed except for people enrolled in Hospice or with End Stage Renal Disease.

Three weeks later the Home Health agency notified her that they could no longer provide services to her mother because of her enrollment in the HMO. Upon investigation she found that the HMO agreed to evaluate her mother for care, but that an agency from outside their county would have to provide care and she would only be approved for 2 weeks of care. With that she promptly disenrolled her mother. If better information had been available the cost of switching in and out of the program could have been avoided, and in the long run her enrollment in the HMO might even have been a good choice. Marketing practices are one of the most common HMO problems causing people to seek help from HICAP.

Managed care depends on a system of incentives and disincentives to control utilization and medical costs. There is a delicate balance between legitimate strategies to hold down medical costs and the failure to provide necessary medical services. Inherent in controlling costs in an extremely competitive environment is the incentive to underserve. There must be adequate safeguards so that seniors get needed health care services.

On site reviews of Medicare Risk HMO's are conducted infrequently, and there is no data available to determine what effect an HMO's procedures for controlling high cost medical services have on the ability of enrollees to get needed care. A 1993 study by the Center for Health Care Rights (formerly the Medicare Advocacy Project, Inc.) in Los Angeles found significant differences in hospitalization rates and heart bypass surgery among the three largest Medicare Risk HMO's in California. While there is a measure of protection in Medicare Risk programs, the financial incentives to deny high cost services are good reason for more comprehensive oversight by state and Federal regulators, and reliable, standardized data collection.

Older consumers are reluctant to complain when they are denied services they need and they seldom know what to do about it. For example, a HICAP client was recently admitted to a skilled nursing facility as a private pay patient after a verbal denial of her stay by a Medicare Risk HMO. This elderly woman had just been transferred from the hospital with acute leukemia after her internal bleeding was controlled. She was waiting to be admitted at the nursing home when the denial was given. She was discharged home after 21 days where she later died. At no time was she told of her option to request Hospice, in spite of the HMO's responsibility to inform her of that option and help arrange it. Had she been able to take advantage of the Hospice benefit all of her expenses would have been fully covered and her last days would not have been spent in financial and emotional distress.

Not only was this woman and her family unaware that Hospice benefits were available, but they had no idea they could appeal the denial by the HMO. The HICAP project has appealed the HMO decision, and also asked that the state agency review this and four other similar cases in the same HMO.

HMO's frequently render verbal denials for care. When there is no written denial a beneficiary is precluded from exercising their rights to an appeal, even if they know they can appeal and are physically or mentally able to complete the process. Verbal denials should always be followed by written denials, with directions on how to appeal the decision and community programs that are available to assist in the appeals process. While there are requirements that HMO's provide written notice, that requirement is often not met.

While managed care is clearly the wave of the future, Medicare beneficiaries are trading the unrestricted use of their benefits for the care provided by a Medicare Risk plan. This arrangement requires a greater scrutiny of how those benefits are provided within a restricted network of providers. The Center for Health Care Rights study also found a disturbing trend in the ability to obtain authorization for

a number of post-hospital follow up services, including home health care, durable medical equipment, acute care rehabilitation and skilled nursing facility care. It is a careful and delicate balance to provide needed care while holding down the cost of individual services as well as the overall use of services through financial incentives and disincentives.

Last year I wrote several letters to Congress in support of the extension of the Medicare Select program. The majority of those enrolled (400,000 plus) in the selected States would have been disadvantaged if the program had been abruptly terminated. Especially in view of the intense marketing of the program in California that resulted in large numbers of people signing up in the last quarter of 1994.

The Medicare Select program offers another method of combining Medicare benefits with managed care. There are however some concerns about the current operation of the program that this committee should consider.

A recent article in *Consumer Reports* magazine found a large number of Select plans in their top rated Medigap plans had lower premiums than traditional MediGap policies. One reason for these lower premiums is that many of the plans use attained age to set premiums. Briefly this means that a person will pay much less in the younger age groups, but their premiums will automatically increase as they age, in addition to any other premium increases that will occur. The danger here is that just when people begin to need more and more medical care, they will also be hit with much higher premiums. Alternative methods of calculating premiums mean that older beneficiaries will almost always pay less than with attained age rates.[3]

Another reason that rates may be less for Select products is non-payment of the Part A deductible to network hospitals. This fact must be crystal clear in advertising and in the plan documents if the Select Plan will not pay this benefit when a person uses non-network providers. There should also be some concern that these uncollected costs will be shifted to private payers, primarily employers.

The NAIC Model allows people to get a non-network policy with equivalent benefits if they decide to leave the Select network after a 6-month trial period. This provision was negotiated within the NAIC working group composed of regulators, insurers and consumers.

Managed care is new to seniors. If they trade their right to use the providers of their choice for managed care and later want to go back to the fee for service program they may find they cannot get indemnity insurance due to their health conditions. The NAIC provision was to ensure that similar benefits would be guaranteed issue and that there would be no waiting periods for those health conditions. The largest number of Select plans are provided by Blue Cross Blue Shield plans, or HMO's that do not offer a standard MediGap policy. A requirement for an annual Open Enrollment Period for Medicare Select plans would dovetail with the Medicare Risk annual open enrollment requirement giving each participant in a managed care option the same protections if these plans are not what they expected.

There are also issues of quality of care, and cost shifting in the event that Select plans are given Part B safe harbors. Doctors are increasingly being forced into managed care arrangements at the same time they resist taking Medicare assignment. It is hard to know how providers will respond when the reimbursement they receive drops below what they consider acceptable, and there is no other market in which to participate. While the field of health care providers continues to grow and the numbers of people needing care expands, the amount available to pay for care is shrinking. Providers are being forced to do more work with larger numbers of people at the same time that they are being asked to accept less money per unit of service. There will be an inevitable reaction to these dynamics, and this trend needs to be carefully watched. Managed care has been able to achieve big savings over traditional fee for service programs, but there is a limit to those savings. The limit will be when that subtle transition takes place between managed care and rationed care.

There is already obvious stratification in the health care delivery system according to the source of reimbursement. Medicare beneficiaries are already beginning to see their medical benefits treated by provider's in the same way they treat Medicaid recipients. Some doctors have begun to refuse to see new Medicare patients because of the low level of reimbursement.

As you deliberate these issues, please keep in mind that the Medicare program is extremely valuable to seniors and a very popular program. The universality of the benefits mean that seniors are covered for the same benefits no matter where they live, and that those benefits don't change if they later have to move to another State as they age, and need more care or support from once distant families. There

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[3] James S. Lubalin, Ph. D., Steven A. Garfinkel, Ph.D., *Evaluation of Medicare Select Amendments,* pg. XX-1 February 10, 1994.

are few seniors, or their families, that could afford to provide the medical coverage currently available under Medicare. There are even fewer seniors and families that can afford, either in money, time, or energy the kind of care that Medicaid pays for in nursing homes. Long term care in a nursing home is the last resort for most people, and a step to be avoided at all costs. Those who spend their last days there have no other options left.

Most seniors are in the middle class or below and are already spending about 23 percent of their income on health care expenses according to the American Association of Retired Persons, while those under 65 spend about 8 percent. As people age their income and resources go down over time, particularly for older widowed women, and out of pocket costs for health care consume an increasingly larger part of their income. Their ability to absorb additional costs in premiums, deductibles and coinsurance is limited.

Thank you for the opportunity to comment on these important issues.

Mr. BILIRAKIS. Thank you.

Mr. Cronin.

STATEMENT OF KEVIN T. CRONIN

Mr. CRONIN. Thank you, Mr. Chairman, members of the subcommittee.

My name is Kevin Cronin. I am Washington counsel for the National Association of Insurance Commissioners, the NAIC. NAIC's Recording Secretary in Wisconsin, Commissioner Josephine Musser, sends her regrets. She started out this morning quite early around 5 o'clock and made it from Madison to Detroit, but made it no farther than that, given that our airports here were closed.

The NAIC is the Nation's oldest association of State government officials. Our members are the chief insurance regulators of the 50 States, the District of Columbia, and four U.S. territories. On behalf of the NAIC, I want to thank you for the opportunity to discuss the Medicare Select program.

Mr. Chairman, in addition to conveying to you NAIC's position today, we are joined in our position by our sister State organizations, the National Governors Association and the National Conference of State Legislators. We support extension of Medicare Select to consumers in all 50 States and the elimination of the sunset provision.

Medicare Select offers choice and it offers savings. Consumers like it. Medicare Select is simply a policy that utilizes managed care. To receive full benefits, policy holders use network providers and incur larger expenses only if they go outside the network.

Wisconsin is a State that has had a well-established and successful managed-care supplement insurance market. With the enactment of OBRA 1990 and the Medicare Select program, Wisconsin recognized that in order to maintain this market, Wisconsin needed to be 1 of the 15 States chosen to participate in the Medicare Select demonstration project. Among the others are California, Illinois, Texas, and Washington State.

Wisconsin has been very pleased with Medicare Select. They found that it works. They found that people in that State save money and they are very satisfied with the program.

When Congress instructed the NAIC to draft Medicare Select standards in 1990, we developed strong consumer safeguards. Insurers selling Medicare Select patrols must file a plan of operation with the insurance commissioner demonstrating that the network provides sufficient access to care, an ongoing quality assurance pro-

gram, disclosure of network restrictions at the time of enrollment, provisions for out-of-area and emergency coverage, and the availability and cost of all Medicare supplement policies without network restrictions offered by the insurer.

Also, the NAIC is in the process of developing health plan accountability standards including quality assurance standards which will further protect consumers in all health plans. Over the last 5 years we found that about 2.2 percent of the Wisconsin department's Medicare supplement complaints were lodged against HMO Medicare supplement insurers.

In addition, Medicare Select coverage is cheaper, a full 20 to 30 percent cheaper than indemnity policies. That can be as much as $500 more per year in the pocket of the average 85-year-old beneficiary.

The NAIC has many reasons for supporting Medicare Select nationally. The program offers premiums 10 to 30 percent below those of other supplement policies. It is hardly pocket change to a consumer on fixed income.

As to consumer satisfaction nationally, we looked at closed complaints in 10 Medicare Select States for 1994. Nine hundred sixty-seven complaints were against non-Select policies. Select policies accounted for a mere nine complaints.

Again, we stress that we cannot stress strongly enough the choice Select policies offer Medicare supplement consumers. Not giving consumers in all 50 States the choice, or worse, yet taking the choice away from consumers in the 15 demonstration States, would harm both our consumers and destruct marketplace.

We also asked you to consider the effects on current Select policyholders if the program is not extended. Premiums will go up in a hurry. While current Select policyholders would be allowed to remain in the program, their premiums will increase as they grow older. The result is premiums that will be beyond the reach of most consumers.

If the program is expanded to all 50 States, we believe more insurers will enter the Select market. We support the extension and expansion of program to all 50 States. We believe with the experience, particularly that reflected in the statement I just gave to you prepared for Josephine Musser, has been a success and we have high hopes in the program if you will extend it.

We look forward to working with the subcommittee on this issue. And again, thank you for the opportunity to testify.

[The prepared statement of Josephine W. Musser follows:]

PREPARED STATEMENT OF JOSEPHINE W. MUSSER, RECORDING SECRETARY, NAIC

Mr. Chairman and members of the subcommittee, my name is Josephine Musser. I am the Recording Secretary of the National Association of Insurance Commissioners (NAIC), and the Commissioner of Insurance for the State of Wisconsin.

The NAIC is the Nation's oldest association of state public officials, composed of the chief insurance regulators of the 50 States, the District of Columbia, and four U.S. territories. On behalf of the NAIC, I want to thank you for the opportunity to appear before the Subcommittee on Health to discuss the Medicare SELECT program.

NAIC supports the extension of Medicare SELECT to all 50 States and elimination of the sunset provision. I am pleased to be here today to testify in support of our position. I am also pleased to report to you that the National Governors Association (NGA) and the National Conference of State Legislatures (NCSL) joins the NAIC in our position before you today.

Today I will discuss the Medicare SELECT program generally; the experience of the State of Wisconsin as one of the States participating in the Medicare SELECT demonstration project; the savings accruing to beneficiaries with Medicare SELECT policies; the high level of consumer satisfaction with Medicare SELECT policies; the added choice the existence of these policies gives to Medicare beneficiaries; and the adverse effect the sunset of the program would have on Medicare beneficiaries. I will also discuss the fact that Medicare SELECT policies are supplemental insurance products and cannot be compared to Medicare Risk contracts.

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) limited the sale of Medicare Supplement, or Medigap, insurance policies with a managed care or preferred provider component to 15 States for a 3 year demonstration period. (The 3-year period expired on December 31, 1994, and, in the fall of 1994, Congress extended the program for another 6 months through the Social Security Act Amendments of 1994). OBRA 1990 also provided for standardization of Medigap policies. Pursuant to that legislation, the NAIC adopted the Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act (NAIC Model) that was incorporated into Federal law when the Secretary of the Department of Health and Human Services (Secretary) published this model. This model developed 10 standard Medigap policies, A through J, and set forth the Medicare SELECT standards. Medicare SELECT policies are just like standardized Medigap policies, except that full benefits are paid only when network providers are used.

The Secretary established guidelines for States to request to participate in this demonstration project. The Secretary initially chose the following States for the demonstration project: Alabama; Arizona; California; Florida; Indiana; Kentucky; Michigan; Minnesota; Missouri; North Dakota; Ohio; Oregon; Texas; Washington; and Wisconsin. Oregon and Michigan ultimately withdrew from the project due to lack of interest by insurers, and were replaced by Illinois and Massachusetts.

OBRA 1990 established the minimum requirements for Medicare SELECT policies and the NAIC Model served as the vehicle to implement these requirements. In order to sell Medicare SELECT policies, insurers must file a plan of operation with the insurance Commissioner demonstrating that: (1) the network offers sufficient access to care; (2) the network has an ongoing quality assurance program; and (3) the insurer provides disclosure, at the time of enrollment, of the network restrictions, provisions for out-of-area and emergency coverage and the availability and cost of all Medicare supplement policies without network restrictions offered by the insurer. The plan of operation must also outline certain required disclosures to consumers including descriptions of the network restrictions, the grievance procedure and quality assurance. Furthermore, the NAIC is in the process of developing Health Plan Accountability Standards, including quality assurance standards, which will further protect consumers in all health plans.

As stated above, Medicare SELECT policyholders must avail themselves of network providers designated by the insurer (except for emergency services) in order to obtain full benefits under the policies. This is the main characteristic differentiating SELECT from non-SELECT Medicare supplement policies, whose policyholders have no such provider restrictions. Under both types of policies, Medicare pays a significant portion of a bill irrespective of the provider chosen by the policyholder, but the policyholder's cost-sharing portion will be larger if a SELECT policyholder obtains services outside the network.

A Congressional Research Service Report for Congress on this program estimates that as of October, 1994, 450,000 persons were enrolled in Medicare SELECT.

In all States except Massachusetts, Minnesota and Wisconsin, the Medicare supplement policies conform to the standardized A through J NAIC model plans. This is also true for SELECT policies. Massachusetts, Minnesota and Wisconsin were granted a waiver from the standardization requirement because they had standardized programs in place prior to the NAIC models. In those States, the SELECT policies must conform to the existing state standardization requirements.

Managed care Medicare supplement coverage has not been a stranger to Wisconsin. Well before the enactment of OBRA 1990 and the establishment of the Medicare SELECT demonstration project, Wisconsin already had a good portion of its Medicare supplement insurance market in private managed care (HMO) insurers. Since OBRA 1990 prohibited the sale of private managed care Medicare supplement insurance, except as Medicare SELECT, it was vital that Wisconsin be one of the 15 States in the Medicare SELECT demonstration project.

At the end of 1993, there were 321,336 Medicare supplement insurance policies in force in Wisconsin. The number of HMO Medicare supplement insurance policies (SELECT) in force at the end of 1993 was 41,016, or 12 percent of the total market. This figure includes 12,430 enrollees in Health Care Prepayment Plans. As you can see, managed care Medicare supplement coverage is a substantial part of Wiscon-

sin's Medicare supplement market and affects many thousands of Wisconsin citizens.

Wisconsin consumers are satisfied with their managed care Medicare supplement coverage. The Wisconsin Office of the Commissioner of Insurance receives about 9,500 written consumer complaints annually for all lines of business. In the last 5 years, the office received a total of 1,984 Medicare supplement insurance complaints, of which only 45 or 2.2 percent were complaints against HMO Medicare supplement insurers. Clearly, managed care Medicare supplement insurance has been a well-received, successful product in Wisconsin.

In Wisconsin, HMO Medicare supplement insurance or Medicare SELECT coverage is cheaper than indemnity Medicare supplement coverage. Depending on age and geographic location, Medicare SELECT policies are 20 to 30 percent cheaper than indemnity Medicare supplement policies. That can be a savings of as much as $500 per year, on average, for an 85 year old beneficiary.

As I mentioned earlier, Wisconsin had an active HMO Medicare supplement market well before OBRA 1990 and its Medicare SELECT demonstration project. Wisconsin's market was comprised of federally sponsored programs such as Health Care Prepayment Plans and Medicare Risk policies, and private HMO Medicare supplement plans. We have actively regulated the private HMO Medicare supplement plans and the supplement portion of the Federal programs. In fact, many of the provisions currently a part of the Medicare SELECT requirements were already in place as part of Wisconsin's regulatory framework for managed care Medicare supplement coverage. From Wisconsin's standpoint, we would hope that Congress would at least see fit to extend Medicare SELECT to all 50 States and eliminate the sunset provision. Without such action, more than 28,000 Wisconsin citizens would be placed in a very costly position.

NAIC supports the expansion of Medicare SELECT to all 50 States, and the elimination of the program sunset provision. As you know, Representatives Johnson and Pomeroy and Senator Chafee have introduced legislation which would do just that. For a number of reasons, we strongly support these efforts.

I would like to point out what Medicare SELECT does for SELECT policyholders. The primary reason the NAIC supports the extension and expansion of the Medicare SELECT program is due to the savings it offers to the beneficiary. As stated earlier for Wisconsin, and now nationally, various sources have indicated that across the demonstration States the SELECT program offers premium savings to Medicare beneficiaries ranging from 10 to 37 percent off of the cost of premiums for other supplemental products. That is a significant amount of money to persons on a fixed income. Furthermore, it is reasonable to assume that the existence of SELECT policies acts as a check on the price of non-SELECT Medicare supplement policies. If competition is eliminated from the marketplace by the sunset of the Medicare SELECT product, there exists the possibility of rising premium prices in the marketplace as a whole.

Second, there is a high degree of consumer satisfaction among SELECT policyholders. The statistics I proffered earlier regarding the extremely low occurrence of consumer complaints regarding the SELECT product in Wisconsin have been replicated among the demonstration project States. In fact, 10 Medicare SELECT States, Arizona, California, Florida, Illinois, Indiana, Kentucky, Missouri, North Dakota, Texas, and Wisconsin report Medicare supplement complaints to the NAIC's Complaint Data System. Of the records received so far for closed complaints in 1994, only nine are against Medicare SELECT policies and 967 are against non-SELECT Medicare supplement policies.

Third, the existence of the SELECT product offers Medicare beneficiaries a choice among the array of Medicare coverage options, particularly since it is the only Medicare supplemental product that incorporates elements of managed care. Options currently available to Medicare beneficiaries include Medicare Risk and Cost Contracting programs, which provide non-supplemental and supplemental benefits. For supplemental coverage, beneficiaries can choose between standardized Medicare SELECT and nonrestrictive Medigap policies. Thus, Medicare SELECT creates an additional option among the entire spectrum of available products and structures relating to Medicare and Medicare supplemental coverage.

There are also several points that need to be made about the effect on current SELECT policyholders of not extending the program. If the program sunsets, no new enrollees will be allowed in the program and premiums will increase for current SELECT enrollees. While current policyholders will be allowed to remain in the Medicare SELECT program, without the infusion of new members, premiums will increase as the policyholders age, reflecting the increased adverse experience of the aging policyholder base. It is likely that ultimately the premium will become unaffordable for persons stranded in the program (the premium "death spiral"), and

policyholders could be forced into the indemnity Medigap insurance market, and be otherwise uninsurable.

Another problem which could occur if the Medicare SELECT program is not extended is that the SELECT provider networks would likely deteriorate. If there are no new members in the SELECT program, providers who decide that it is not worth the administrative burden to participate in a program which is not enrolling new members could drop out of the SELECT network. This could result in a collapse of the network and immediate loss of services to beneficiaries if there are no contracted providers to deliver care.

Some have expressed disappointment that more insurance carriers are not participating in the Medicare SELECT program. However, the lack of insurer participation may be attributed to the finite nature of the demonstration project. Many carriers were reluctant to enter the market with a new product when the market was limited to 15 States and the product might be terminated after 3 years. Most carriers believe that it takes 2 to 3 years to develop a product, price it, and obtain regulatory approval, and 4 to 5 years to obtain good data on the new product. It is entirely possible that with the extension and expansion of Medicare SELECT to all 50 States and the elimination of the sunset provision, more carriers will enter the SELECT market.

Now I would like to talk briefly about what Medicare SELECT is not. It is not the Medicare Risk program. Medicare SELECT is a Medigap policy—a supplemental insurance product. That fact needs to be underscored to prevent inappropriate comparisons with other managed care options available to Medicare beneficiaries. For example, standards and expectations applicable to Medicare Risk contracts, which affect the full spectrum of services received by Medicare beneficiaries, are not necessarily transferable to the Medicare SELECT program, a supplemental insurance product designed to pay benefits relating to gaps in Medicare coverage.

One of the goals of the Medicare SELECT program is to introduce the Medicare beneficiary portion of the population to concepts of managed care. It is important to note that managed care is in different developmental stages throughout the States, and is not as developed elsewhere as it is in States like Wisconsin and California. However, the introduction of the concept of managed care to Medicare beneficiaries is being achieved in the SELECT population by use of HMO's, such as in Wisconsin, and by the use of preferred provider organizations with contracted networks of providers in other States. In many areas of the country, a Medicare Risk contract is not an option for a Medicare beneficiary. If the intent in the long run is to make a transition of all Medicare beneficiaries into the Medicare Risk or similar Medicare managed care program, it well serves that purpose to have Medicare SELECT available to those portions of the Medicare population where Medicare Risk is currently unavailable to introduce them to elements of managed care.

The NAIC supports the extension and expansion of Medicare SELECT to all 50 States. Certainly, Wisconsin considers managed care Medicare supplement coverage and its Medicare SELECT demonstration project to be a success, and has high hopes for the program as a whole. The task of introducing the Medicare population to managed care is certainly worthwhile but will take time. Medicare SELECT is a product which we believe provides meaningful Medicare supplement coverage, helps in introducing Medicare beneficiaries to managed care and saves beneficiaries money.

We look forward to working with you on this issue. Again, thank you for the opportunity to testify.

Mr. BILIRAKIS. Thank you, Mr. Cronin.

Well, let's see. I will ask Mr. Norwood to start the questioning.

Mr. NORWOOD. Thank you, Mr. Chairman.

My question to start off with is to Mr. Bradford and Ms. Lehnhard.

I am just curious, do you believe that managed care is better today than fee-for-service care in terms of service and in terms of actual health benefit?

Mr. BRADFORD. I do. Managed care is the only one of the various Medicare options that members have to choose from where there is a systematic measurement of performance across populations, epidemiological measures of wellness, of residual diseases, of complications——

Mr. NORWOOD. Do you believe that if you take the dollar figure out of the equation, do you believe managed care is better than fee-for-service care if you take the dollar out of it?

Mr. BRADFORD. I am not sure if I understand your question.

Mr. NORWOOD. Remove the consideration of cost. Is managed care a better way to receive health care and a better service than fee-for-service?

Mr. BRADFORD. If money was no issue, I would continue to have my family's care delivered in a managed care setting, yes.

Mr. NORWOOD. Okay. You want to see the Medicare Select program extended with regard——

Mr. BRADFORD. I do.

Mr. NORWOOD. [continuing] to all 50 States.

Mr. BRADFORD. Yes, sir.

Mr. NORWOOD. And you say you want that extended because basically the people today who have that program, they think this is the greatest thing they have seen in a long time.

Mr. BRADFORD. In my experience, that is true.

Mr. NORWOOD. Both of you agree with that.

Ms. LEHNHARD. Yes.

Mr. BRADFORD. Yes.

Mr. NORWOOD. Why haven't more companies and more States been clamoring to have this if it is so wonderful?

Ms. LEHNHARD. I can respond to that. First I think there is understandable resistance on the part of the private sector to get into a program that has got a 6-month life expectancy with a very uncertain future. We don't plan in the private sector in 6-month segments; we plan in 3-year and 5-year segments. And there is a history of the government being less than a committed business partner in this program.

We actually had to shut down some programs. We had programs in a number of States much more than 15. After HCFA asked us to start up Medicare Select products, they were very popular and we had to shut them down when they went to 15 demonstration States. So we know there is a demand out there.

We have got 350,000 out of the 400,000 enrollees in BlueCross and BlueShield plans. We know we can do more. Our plans want to start up more. That is why we would like to see it extended.

Mr. NORWOOD. When we started everyone knew it was a demonstration project. It isn't exactly like the government didn't say we are going to try this for a few years and see how it works.

Ms. LEHNHARD. I think it started before it was a demonstration product, before Medigap.

Mr. NORWOOD. Oh, did it?

Ms. LEHNHARD. HCFA came to us and some other companies and asked us to partner with them. It started up, we had conferences around the country. It was a big initiative to start these programs up in several States and we literally had to shut them down.

Mr. NORWOOD. If the government says, yes, it is fine for Medicare to get into managed care, we needn't worry what is going to happen; the world is going to clamor to your door. Everybody is going to love it. Everybody who is on Medicare today will want to be in Medicare Select according to what you are saying.

Ms. LEHNHARD. No, I think we have to prove to the customer, the consumer that there is value in this.

Mr. NORWOOD. Well, I know, I realize you do, but then you say from the past few years we have proven that to ourselves. You have proven it to yourself that people will clamor to your door and this will be something that the public will want.

Let's make that assumption if we could. If from my point of view, I want to know how the Select program will help the United States Government afford Medicare, and you both have said in your testimony that you could prove this, prove that. However, HCFA can't seem to prove anything. They don't know enough to give us a report on time.

Can you give this committee in writing absolute proof and what percent of savings will come to the Federal Government if we go with managed care?

Ms. LEHNHARD. Can I respond to that by separating the two and we can give you some studies on savings from managed care, and that is evolving. But I would make a point about Medicare Select that I think has been perhaps misunderstood today.

Medicare Select was not put in place to save money for the Federal Government. It was put in place to save money for people who buy Medigap premiums. And in the Medicare HMO product, the government is very much at risk in overpaying. The 18-76 capitation programs, you need to be very careful, and Medicare based on risk selection could overpay.

You don't have that problem with Medicare Select. There is no risk to the government in overpaying or losing money in Medicare Select, so what you have is a situation where if the government doesn't extend this program, the government is saying to Medicare beneficiaries, I know you are saving money, but because you can't absolutely prove to me that I am saving money I am not going to extend it; I am not going to let you continue to save money.

Mr. NORWOOD. You may be exactly right and maybe that ought to be one of our options, but what we are trying to do is figure out how this country is going to pay for Medicare and I want you to tell me because you have said in your testimony there is great savings in this for the government. I don't want a study. I want somebody to give us proof there is great savings in this. We need to know that. If there are great savings in managed care for the United States Government, that may be the salvation for Medicare.

Now, if you have that information, can you give it to us with a reasonable percent of what might be saved?

Mr. BILIRAKIS. The gentleman's time has expired, but I will allow a brief answer to that question. It certainly is a very significant one.

Mr. BRADFORD. I can't speak for our whole industry but I can speak for a family health plan which is a very vertically integrated, very managed-care-intensive organization. Our physicians work exclusively in managed care, seeing commercial members alongside Medicare members, and the benefits of managed care in that setting accrues not just to the commercial members but the practices extend to the Medicare members even though we are only partially at risk for the co-pays and deductibles under a Medicare Select arrangement.

Consequently, in our particular setting we experience reductions in hospital utilization in the Medicare population as well as the commercial population. I can't tell you that that will extend to all facets of managed care, only that it works in our particular environment and that it is a cross-fertilization of being exclusively devoted to managed care. Not all plans are exclusively devoted as we are, nor structured as we are.

Mr. NORWOOD. Thank you, Mr. Chairman.

Thank you for your answers.

Mr. BILIRAKIS. Mr. Ganske.

Mr. GANSKE. Ms. Lehnhard, I guess we are in agreement on something. I believe that if this panel or this committee decides to extend this program to all 50 States, we will be sending a clear message. That is partly why I have some serious concerns about doing this at this particular time as we are going to be looking at some other options.

I guess I would like to follow up from some testimony that Ms. Shearer and Ms. Burns gave and ask you, Ms. Lehnhard, a question. Both Ms. Shearer and Ms. Burns talked about or suggested a 6-month open enrollment change in this program. How would you respond to that?

Ms. LEHNHARD. That you would move from the 6-month open enrollment period to continuous open enrollment. We think that that is something that Congress might well want to look at but not with respect to just one product.

You have 450,000 people in Medicare Select and then you have got another 300 million people in other types of products, network products, HMO's. We would urge you to wait and look at that with respect to all of the products, not just Medicare Select and not hold up action on this little bill to examine it. And also, the attained age issue may be something you want to look at, but again, not to hold up this bill by taking on a rather complex issue.

Mr. GANSKE. I guess I would have to disagree with you that this is a little bill. I think that this is a bill that has tremendous significance in terms of giving an indication to industry of where Congress may be going in the next few years. And as we are moving through a very heavy legislative schedule with the Contract With America, I have some reservations about making this decision right now.

I think health care reform is going to be on the agenda of this committee. I know the chairman has been working on this quite extensively. The leadership and everyone else hopes that we will be able to do some significant welfare reform legislation in a broad context over the coming year or two.

I guess, Ms. Shearer, I would like you, if I have got any time left, to just expand a little bit on the Medigap maze. Could you explain that in a little more detail.

Ms. SHEARER. I would be happy to. Of course, Medicare was enacted in 1965 and over the years between 1965 and about 1980, many, many problems evolved in this market. It was a market that was characterized by confusion and by abuses really that led to many seniors buying many, many policies.

In 1990, Congress enacted OBRA 1990, which included significant reforms of this market which set up, really requested the

NAIC to establish 10 standard benefit packages that would enable the consumer to sit down and compare apples with apples.

What is suggested by the Medicare Select program and indeed Medicare risk, all of these other programs make the decisions that seniors face more and more complicated by many dimensions. And I am not saying this isn't always justified, it may well be, but I think it is worth really studying what the benefits of each of these programs are before locking them into place permanently.

Mr. GANSKE. Ms. Shearer, do you think that the final report from HCFA is going to provide us with that much more information?

Ms. SHEARER. I have studied the preliminary report that HCFA received about a year ago. The preliminary report outlined a number of potential problems which really concerned me and I am assuming that the final report is going to look at the questions such as are there true cost savings or is it merely cost shifting, what is the pricing structure for most of these policies. I am not familiar with what the contract is, but my expectation would be that many of the questions that I certainly am concerned about would be answered by that report.

Mr. GANSKE. Thank you.

Mr. BILIRAKIS. Thank you, Dr. Ganske.

Mr. Hastert.

Mr. HASTERT. Thank you, Mr. Chairman.

Mr. Cronin, if the Federal Government also decided to mandate open enrollment for all Medicare supplemental policies in addition to banning age rating, what would that do to the Medigap premiums? Do you think this would cause people to drop their policies?

Mr. CRONIN. I really don't think that they would, Mr. Hastert, but I honestly have to tell you I don't know the answer to that question.

Mr. HASTERT. Anybody else want to take a crack at that?

Ms. AHL. I think that there is actually two. The open enrollment and there are two different issues, and the first is really open enrollment in terms of no underwriting. One of the things in the industry that is real important is whatever happened, happened across the board, don't apply something just to Medicare Select that you don't apply to supplemental insurance.

I think it is very important that you understand that Select is a subset of supplemental insurance. So when you are dealing with issues like attained age versus community rating or you are dealing with open enrollment, you really are talking about Medicare supplement insurance. When you adopt any of those measures, that automatically applies to Medicare Select.

The other issue is I know that there is a proposal floating around in terms of open enrollment having a singular period of time per calendar year, is my understanding, and that is the only time in which seniors could enroll or disenroll in any plan in Medicare, whether it is Medicare Risk, Medigap or whether it is Medicare Select.

My perspective from the senior population is that even though we understand that the thought with HCFA in terms of reducing disenrollment when someone becomes sick is that probably doesn't make a lot of sense. Seniors like much greater choice than that.

I also think that it would also be disruptive to the risk contracting program in that seniors may be less likely to move into a risk contract when they have those kind of locking provisions and they can only disenroll one period per year if they don't care for it.

Generally, when you look at it in the market, if the risk contract is doing a good job of servicing that senior just because they become sick, I think there is more incentive to stay in a managed care plan because of the level of coordination of care. I don't think that that makes a lot of sense.

Mr. HASTERT. Well, Ms. Ahl, let me ask you this: Why do you think we should move forward by extending the program to all 50 States and by making it permanent?

Ms. AHL. I think for a couple of reasons. First of all, Medicare supplement insurance is out there in the market. About 80 percent of seniors will buy some kind or recover by some kind of a Medigap plan. It is already out there. It is a private insurance carve-out of the Medicare plan. It is supplemental insurance regulated by the States. Medicare Select simply offers them another choice. It is a hybrid type of a product.

The issues that refer to Medicare supplement insurance, those are still issues that are open to a great deal more of debate and those can be debated as those issues come up. If you don't send the message out there to the market that you are a good partner in terms of Medicare Select in the process that you have structured, then I think you will end up with a lot of fallout. And I think it is a good program. It is a hybrid product.

Mr. HASTERT. Now it is true that I cannot speak as a physician, as Dr. Ganske can, but one of our goals is to find savings so people have access to more medical services, whether it is pharmaceutical services or others. And in your opinion, then, Medicare Select achieves this goal; is that correct?

Ms. AHL. Are you saying does it save the Federal Government money?

Mr. HASTERT. I mean it saves consumers money, doesn't it?

Ms. AHL. It certainly saves the consumer money in terms of the premium because seniors are buying supplemental insurance and it does save them money and it gives them a chance to buy into a concept that is kind of quasi-managed care.

For example, most of the networks are structured around hospital-only networks. Seniors are okay about buying into a concept with a singular set of hospitals. Even the physician panels that are out there, most of them really don't have a gatekeeper concept. They have to select from a panel, but they don't have to select a singular primary care physician in order to access that care. So it is very, very friendly to the seniors in terms of not truly being a lock-in type of a program.

Mr. HASTERT. The Medicare Select doesn't prohibit somebody from going out and getting fee for service. It gives people choices; is that right?

Ms. AHL. It gives people choices, that is exactly what it does. It gives the seniors choices.

What is important and why it is important to the Federal Government, you know, I truly do believe that managed care saves money. I think the Foster & Higgins report that just came out

clearly is showing that money is being saved in the commercial market because of managed care. There are just not that many options in Medicare managed care.

This is one more opportunity where seniors who have not traditionally been touched by managed care in their commercial lives, they are moving into covered by Medicare. That card out there, that Medicare card out there is all-important to those seniors and to turn that into a locking provision for some of them is difficult. So this offers them a stepping stone.

Mr. HASTERT. Thank you.

Thank you, Chairman.

Mr. BILIRAKIS. Dr. Coburn.

Mr. COBURN. Thank you. I am sorry. I was in and out on this. I was dealing with health care.

Let me ask whoever would want to respond—well, first of all, let me ask Mr. Bradford, if I may, I was impressed with your coverage and no differentiation between the Medicare and the others in your group. Could you share with us the cost participating in your plan.

Mr. BRADFORD. In the State of Wisconsin, the insurance commissioner has obtained a waiver for single as opposed to 10 different options for this and the only variation within that is the range of prescription coverage. We have opted for full prescription coverage.

So in our situation the base Medicare coverage is extended to beneficiaries by the government and we provide copayment and deductible coverage for all of the services that are not covered by the government. And in addition, then extend ourselves to extensive home care and to 365 days a year and to full prescription drug coverage without copayment or deductible.

Mr. COBURN. So in essense, then, it is not truly the same cost for a Medicare patient and a non-Medicare patient in your program because the Federal Government is picking up a large portion of that in addition to the payments.

Mr. BRADFORD. That is the nature of Medicare Select.

Mr. COBURN. I understand that, but I intended to say and I wanted to clarify that because there is a large difference in cost total dollars spent on a Medicare patient in your program versus a non-Medicare patient in your program. Is that correct?

Mr. BRADFORD. That is correct. There is a premium associated with our wrap-around.

Mr. COBURN. And I guess another thing is, why—and anybody can answer this if they would—is, why do you think that we have not seen the savings in all the managed care; in other words, why have more individuals in companies under 500 not seen the benefits of managed care versus those in companies above 500 where is the differentiation there?

Why does the small manufacturer not have or the small company not have the benefit that some of the above 500 have? Where is that cost? If you would care to answer.

Ms. LEHNHARD. I think one answer to that is that the small end of the market, the small employers didn't have the availability of managed-care products as soon as larger employers. I think it has only been in the last few years that we have made managed care products available into the small end of the market, 500, 100. We

are offering managed care products down to groups as small as three and five now.

I think you will see those savings because you are pooling the purchasing power of one large carrier to negotiate on their behalf, to do physician profiling on their behalf. So compared to very large companies, I would say it is a relatively new phenomenon.

Mr. COBURN. But for last year we can see a marked increase in those and a marked decrease in those over 500. That is what was released yesterday.

Ms. LEHNHARD. Yes.

Mr. COBURN. So does some of that have to do with self-insurance for the large loss?

Ms. LEHNHARD. I don't know the response. I don't know the answer to that. I have to get back to you.

Mr. COBURN. Do you find it interesting that in managed care we see such a difference in just in terms of size even given your explanation that we see such a difference in cost increase versus cost decrease in the size of those two organizations?

Ms. LEHNHARD. I don't know. I haven't seen a study so I can't respond to that.

Mr. COBURN. I was pointing out to Chairman Bliley as far as this testimony the information that was released yesterday on the absolute decrease cost of the health care among the private sector in terms of industrial component went down 1.1 percent this last year, as many of us had anticipated it would, and I think if there was any benefit of the last year's health care discussion it was the fact that it tended to temper prices everywhere in the health care field including managed care.

I don't have any other questions. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman's time has expired.

Ms. Shearer and Ms. Burns, is it basically your position or the position of your organizations that you don't think that the program necessarily should terminate at this point in time. You feel that it should be an extension, but it should be an extension shorter than permanency?

Ms. SHEARER. Yes, Mr. Chairman. Our position is give it another 6 months, a year, 2 years, study the RTI study that is due in. Make adjustments, fix what is broken, but don't lock out permanently a program that has problems.

Mr. BILIRAKIS. Ms. Burns, that is basically your position, too.

Ms. BURNS. Well, my position is I don't want to disadvantage the people who are already in Medicare Select and I wrote letters on that last year. But I also don't want to lock in some deficiencies in the system either. So I agree with Ms. Shearer about how we ought to handle that.

Mr. BILIRAKIS. All right. Thank you.

Mr. Bradford, your family health plan cooperative doesn't cover all of Wisconsin, does it?

Mr. BRADFORD. No, we have metropolitan Milwaukee and an affiliate near Madison.

Mr. BILIRAKIS. I see. Is your plan, being a nonprofit cooperative, which probably explains to a large degree what benefits you are able to give for the same amount of money in any case, is that unique?

Mr. BRADFORD. I would think it is peculiar to the laws of incorporation in the State of the Wisconsin that it was advantageous for us to begin in that fashion.

Mr. BILIRAKIS. As far as you know, there are no other similar plans around the country?

Mr. BRADFORD. There are a number. Group Health of Puget Sound, an HMO of some 40 years history and almost 300,000 members, is also a cooperative. There are similar plans——

Mr. BILIRAKIS. Nonprofit cooperative?

Mr. BRADFORD. Correct.

Mr. BILIRAKIS. You made the comment in answering one of the questions that you wouldn't hesitate to enroll your family into that plan because of the efficiency and the special care and that sort of thing.

Do you believe that all managed care plans—when I say all, obviously there are degrees of variation or similarity to yours, or do you think that maybe yours is so much different and so much better, if you will, because of the nonprofit aspect?

Mr. BRADFORD. I represent as an industry a segment and probably a minority of the managed care industry that is highly vertically integrated. On the staff model, HMO build their buildings and employ their physicians directly. That is fairly unique, and I can't really tell you whether or not the performance characteristics of an HMO like mine which is highly coordinated, highly integrated is going to be universal across my entire industry, but I think so, and to greater and lesser degrees as you have indicated.

Mr. BILIRAKIS. What is the cost to an enrollee under your plan versus the cost of an enrollee in, let's say, a BlueCross/BlueShield plan?

Mr. BRADFORD. In Wisconsin, the differences for plain, straightaway indemnity insurance have reached levels of $800 to $900 for a family for a month. And most of the managed care competitors are in the $350 to $450 range.

Mr. BILIRAKIS. In other words, the family health plan cooperative is $300, $350 range.

Mr. BRADFORD. Approximately half of the current indemnity cost.

Mr. BILIRAKIS. It sounds like you do better when it comes to benefits.

Mr. BRADFORD. Typically much better benefits without co-pays and deductibles in our plan, correct.

Mr. BILIRAKIS. All right. Now, the position of the other four of you is that we should make the plan permanent and expand it to 50 States; is that correct?

Mr. BRADFORD. It is.

Mr. BILIRAKIS. And do you feel that permanency as against a shorter period of time extension is necessary at this point in time, considering that we don't have more data available to us.

Ms. AHL. I think that you know partially you are looking at not having the report until the end of the year. I think also that even that report probably will be somewhat deficient in terms of what it can really tell you. These things take time.

You are looking at we don't deal in the private sector with 6 months sections, as was said earlier. When even the enrollment, for example, when a senior changes a health plan, those generally re-

main healthier seniors. A senior who is in the status of life where they are sick or they are vulnerable, they don't make changes in their life and particularly in their health plan.

So you have to give some things time. The law of averages applies, and you know 3 to 5 years down the road, you will be able to look at data that means a lot more to the government.

I think what you need to do is take on the premise that in the commercial market, managed care is working and therefore makes sense that it will work in the Medicare arena. The more managed care active you extend in the Medicare arena, the more you will be able to learn and grow from that.

Ms. LEHNHARD. Mr. Chairman, I also go back to—I agree with everything she said and go back to what the study is going to show. One of the primary things the study is going to look at it is whether or not it saves money to the Federal Government. If it does, that is wonderful. We think it does. And we all hope it shows savings, but if it doesn't, it is not losing the government any money and we know it is saving money for Medicare beneficiaries.

So I think the question is, if you do this study and it doesn't show savings to the Federal Government, are you going to let the program lapse when it saves up to 40 percent for Medicare beneficiaries. So, to me, the study is a plus for something that is a very good deal for beneficiaries and you would want to make sure they had available.

Mr. BILIRAKIS. Well, if it saves money for the Federal Government in addition to doing these other good things, obviously it would be a plus, because let's put yourself in our shoes.

Ms. LEHNHARD. Icing on your cake.

Mr. BILIRAKIS. And what we are facing, and I think that was really the point so many other members were making, if you have evidence statistics or anything to that effect, do yourselves a favor, and us obviously, and submit them to us.

Well, anything else to come before this committee at this point in time? Anything else?

Mr. NORWOOD. No, sir.

Mr. BILIRAKIS. You and I are the only ones left. I appreciate very much your patience in waiting. It is never nice to be the last panel, but it is even worse on a day like this. But unfortunately, that is our world up here at least for the first 100 days.

Thank you so much. You have been a great help.

[Whereupon, at 4:07 p.m., the hearing was adjourned.]

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